Harvard Medical

ALUMNI BULLETIN SUMMER 1992



Across borders

Fellowships for HMS Alumni

1992–1993

Fellowships are available for graduates of Harvard Medical School to undertake a year of post-graduate study. The amounts awarded for stipends are determined by the specific needs of the individual: $20,000 – $30,000 is the norm.

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The Committee on Fellowships gives preference to those Harvard Medical School graduates who:
1
Have already demonstrated their ability to make original contributions to knowledge.
2
Have planned a program of study which in the Committee's opinion will contribute significantly to their development as teachers and scholars.
3
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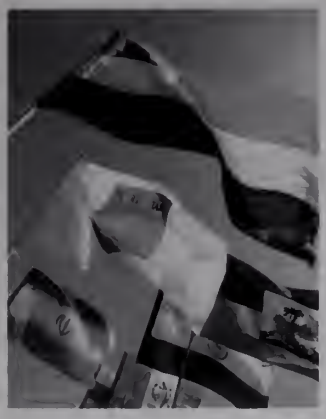
The Committee requests that applications be submitted not more than one year in advance of the requested beginning date. The Committee meets once a year in January to review all applications on file by December 31. Applicants will be notified by February 15.

Information and application forms may be obtained from:

Committee on Alumni Fellowships
Harvard Medical School
Room 414, Building A
25 Shattuck Street
Boston, Massachusetts 02115

Summer 1992
Volume 66 Number 1

Harvard Medical
ALUMNI BULLETIN



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Inside HMAB

As the song goes, "We are the world," and in this issue the 'we' is Harvard Medical School and its graduates. Many alumni are engaged in making the world a better place, such as Paul Farmer '91, who has been caught up in the politics of poverty in Haiti the past decade, helping design and implement community health programs.

Other faculty and alumni crusade internationally against human rights abuses. As reported by Assistant Editor Terri Rutter, HMS recently co-sponsored a continuing education course on how physicians can use medical skills to treat or advocate for victims of such abuses. We then move to a decription of Soviet medicine before and after the break-up of the union, by Mark Field, an emeritus professor at Boston University and currently a fellow at Harvard's Russian Research Center.

We catch a glimmer of another age through the photographs of anatomical exotica by Rosamond Purcell, who has traveled to Holland, St. Petersburg and Spain to capture what Gordon Scannell '40 in his introduction calls "a world of wonders."

Farrokh Saidi '54 has translated from Farsi a turn-of-the-century story about a Ghashghai tribal boy who becomes a doctor. Stanley Bennett '45 tells of his experience as a Peace Corps physician in western Africa facing an epidemic of chloriquine-resistant malaria. And Rodolfo Herrera '42 relates how he returned to Guatemala after many years of education abroad and founded a medical school.

Jim Thomas '81 tells what he learned about Gypsies and their culture from treating them at MGH. And, in keeping with the spirit of Schweitzer, three alumni—Bob Goldwyn '56, Patricia Schaffer White '86 and Lachlan Forrow '83—appeal to other physicians to get involved in the less exotic but equally compelling opportunities for altruism here at home.

Ellen Barlow

Harvard Medical
ALUMNI BULLETIN

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Letters

Much appreciated

Congratulations on the current issue of the *Bulletin* (Spring 1992). It seems to me a very good thing to give the nonacademic alumni this kind of opportunity and recognition, and the result was a set of very interesting contributions.

Bernard D. Davis '40

Halloween Justice?

I commend the willingness of those two second-year students to write that letter of apology to their community for facial make-up and costumes at the Cannon Ball on Halloween night, as published in the *Bulletin* (Spring 1992). It took a measure of humility and grace to do that considering what they had already endured. I also applaud them for their generosity of spirit in not initiating a civil suit against their fellow student.

I condemn the punitive measures taken against those two students by the Review Committee for the following reasons. The punishment was immoderate and "criminalizing" an "insensitivity" (which once was referred to as "bad taste") and is unjustified. The Committee's interpretation of the offence seems to have been viewed outside of the festive context of the dance. The right to freedom of expression has long been confirmed by the Supreme Court. The desecration of the American flag, though in bad taste, is not considered a crime.

In my view, the punishment was excessive. One of the second-year students suffered the indignity of being publicly assaulted, having the enjoyment of an evening ruined for both him and his friends, the pain and scars of a facial laceration, the ignominy of having to go to an emergency room for suturing (did he also have to wait in line?), the innumerable hours of depositions and cross examination and the disgrace of being dragged before a hearing panel, the intrusion upon his privacy (as the "Halloween Incident" has assumed nationally the painful publicity of an inquest) as well as the blight on his personal administrative files at the school. It all could have been settled in a more gentlemanly way.

Of more concern to me was the official action by the Review Committee to "criminalize" an act of bad taste, by imposing sanctions ("...the task of preparing by the end of the academic year a syllabus and biography...etc"). No civil rights violation has been asserted. In its own conclusion the committee states that the student's "action stemmed from ignorance and not malice." Since when have reasonable men decided to punish ignorance? Is this not "creative law" at its worst? Overcome it, yes! but punish it, no! Singling out for persecution two individuals for the pervasive "sins" of others, as the ad hoc committee will surely discover, is not a value upon which this nation was founded.

C. Newton Peabody '48

Re: "The Halloween Incident." I usually do not read carefully, certainly not word-for-word, HMS mailings, but this article gripped my attention. I have no reason to question the facts, nor am I qualified to dictate the actions, but there were some larger issues glossed over, almost as straining as gnats while swallowing camels.

I am a Caucasian, from a Caucasian family, who has had a lot of contact with black people in various situations from early childhood. I have personally experienced a bizarre side of life such that I have been treated worse than many blacks. In 1988 I experienced the loss of my practice, prolonged unemployment, a serious illness, the death of a parent and other major losses all in one calendar year. I am not the same person I was five years ago.

One thing I learned or decided is that the more pathetic one's situation becomes, the more important is a sense of humor, to laugh at yourself and your life. How miserable to be in a bad situation and not even be able to laugh. In my opinion, one measure of anyone's maturity is the ability to laugh at yourself, and of immaturity is your inability to do so. The issue is not respect/disrespect but rather achieving that middle ground of alert poise, avoiding the extremes of uptightness or downlooseness.

Another "camel" in that article is the beer spilled on someone. As an active Christian layman who used to conduct a medical clinic at a local rescue mission, and the father of three children, now 16, 21 and 22 years old, I years ago checked the Bible very carefully and learned I am not to get drunk—which I have never done—and I am not to cause someone else to stumble by drinking alcoholic beverages myself. In my opinion, to avoid causing problems for others, alcohol should be prohibited from all HMS functions and certainly removed from the Vanderbilt Hall dining room! This is a far larger issue, potentially affecting many more people and even future generations, than a guy losing his cool and taking a swing at some dude in costume!

A final "camel" is the appearance of a student at the Halloween party dressed as some porno star. Pornography is a deadly evil, which has slithered into the deep recesses of many a mind for decades. The effect is far worse than mere sexual stimulation, rather a "staining of the mind," which may take years to resolve after the victim realizes what has happened. Pornography has no place at HMS!

Richard N. Lamb '61

Letters

Cocoanut Grove Remembered

I recall vividly both the horrors as well as the many examples of courage and devotion to duty that I witnessed, as a fourth-year student at HMS, "across town" at the Boston City Hospital on that memorable weekend in November 1942. (The nurses, house staff and students came to detest the vaunted "triple-dye" treatment of burns!) Still, the Thorndike group did make fundamental contributions in nutrition and respiratory care in managing the many hundreds of burn patients seen at the BCH.

"Bud" Relman's interesting article on the evolution of the *New England Journal of Medicine* in the Winter 1991/92 issue also intrigued me, as a devotee of medical history. Initially puzzled by his reference to Dr. Fitz's description of acute pancreatitis, I consulted several texts (Garrison, et. al.) and confirmed this fact. However, I was amazed to find how little credit Fitz received for his even more noteworthy description of acute appendicitis in 1886! I also learned that the first surgeon to diagnose this entity prior to rupture, to operate and to have his patient survive was a Dr. N. Senn (*JAMA*, 1889).

Charles A. Kane '43A

I'd like to commend yet another outstanding issue of the *Alumni Bulletin* (Spring 1992). I was particularly interested in the articles on the Cocoanut Grove fire. Like so many others who were around at that time, it was an experience I can never forget. I was a third-year student and, as I recall, I was taking third-year surgery at the MGH. I turned up and was assigned to take care of one of the patients, a well known cowboy movie star of that era. I am trying to think who it was; the name that keeps coming up in my mind is Hoot Gibson, but I can't be positive. (*Ed. note:* A search through newspaper archives revealed that the cowboy in question was Buck Jones.) In any case, I remember that he did not have any significant external burns but his respiratory tract had been irreparably damaged and he died after a few days in the hospital.

One of the impressive learning experiences that most of us had was not mentioned in any of the articles, namely, a session given by Drs. Edward Churchill, Oliver Cope and others about two or three days after the fire. They provided a detailed review of the entire episode, with emphasis on management of the patients, and everyone who spoke did a superb job.

Robert J. Glaser '43B

The heroic and overburdened doctors at the MGH and Boston City Hospital learned many valuable lessons about treatments of burns from the infamous Cocoanut Grove fire.

Undoubtedly insignificant by comparison to that tragedy was an observation to do with the need for medical care, which came out of the lack of an appropriate dispatching mechanism at the site of the fire. The BCH, and immediately thereafter the MGH, received overwhelming loads of patients in a very short time, resulting in them closing their doors for a time. Ambulances were then directed to a wide variety of hospitals, including those as far away as Concord, Massachusetts. There were not a proportionate number of patients sent to the very nearby New England Medical Center or the Boston University hospitals.

At the Peter Bent Brigham, where I was an intern, the plan for a war-time emergency evacuation of the hospital in the event of a bombing of Boston was put into effect. This had been worked out by Thomas B. Quigley '33 and J. Egbert Dunphy '33 before they departed for service in the armed forces. The entire staff on duty and off duty were summoned to the hospital, and we made a quick check as to which patients absolutely could not be moved with reasonable safety from the hospital. By Sunday morning [the day after the fire] we had 17 patients in the entire hospital. We received only three living patients from the fire, and it is my recollection that one of them was sent home that same night with no serious injury. We did receive a large number of corpses.

As a result of the overwhelming load of the MGH and BCH, physicians in eastern Massachusetts were urged very strongly not to send anyone to the hospital except in dire and pressing necessity. As the two biggest hospitals in Boston were not receiving patients, we naturally expected a huge number of admissions, but the conscientious physicians of Massachusetts cooperated with the plea and the curious result is that we had fewer admissions than usual.

It is my recollection that it took over two weeks for the hospital to be completely full again. I have tried, without success, to find the exact numbers from Blue Cross and from the Brigham's records, because it seems to me that there was a valuable lesson to be learned in the absolute necessity for hospitalization. In these days of cost containment and arguments about the need for hospitalization, I often recall that period. Almost every patient who is admitted to the hospital today sup-

posedly meets tough standards of Utilization Review, but looking back to a time when absolute need was the criterion, we have food for thought.

Curtis Prout '41

One Sunday afternoon a few weeks ago, I was pressed for an idea for my free-topic paper due the next day in my 10th grade English class. When I asked my father (Gordon P. Harper '69) for something to write about, he called my attention to the section in the Winter 1991/92 *Bulletin* concerning the 1942 fire at the Cocoanut Grove.

I read the experiences of Thomas Coleman and Francis D. Moore as physicians on the scene. I found their accounts of the fire so interesting, I decided my topic would be a fictional personal account of that night. The articles from the *Bulletin* provided the background for my paper.

I would like to thank Drs. Coleman and Moore for writing such fascinating pieces and the *Bulletin* for publishing the section on the tragic fire, which increased my awareness of this aspect of Boston's history as well as helping me begin the term with a paper of which I, as well as my teacher, felt proud.

Molly Harper

More on Harry Solomon

Thank you for printing the generous letter of Raquel Cohen '49 recounting Dr. Harry Solomon's early understanding of the value of helping individuals deal with the twin pressures of personal and professional life by relaxing formal codes of job descriptions. Before he helped her by arranging a half-time residency spread over four years, he enabled a psychiatrist at the other end of the medical cycle to continue his career with dignity. In the late 1930s, by creating Baldpate, a private mental hospital, Dr. Solomon not only facilitated the emigration of a prominent Viennese psychiatrist, George Shlomer, but also made him a partner—indeed, medical director—of the facility. Thus, Dr. Solomon endowed a distinguished refugee with a dignified post while he learned English, became a citizen, and gained a license.

Much earlier, as a young researcher at the Boston Psychopathic Hospital working under Dr. Elmer Southard after World War I, Dr. Solomon brought his wife, Maida, into his office as an untrained volunteer, to use her energies helping with patients' families: the start of her career as one of the first professors of psychiatric social work. That he gained as much as he gave was typical of his career as a gifted administrator (which culminated in his 70s, after retirement from Harvard, in a decade as Commissioner of Mental Health of the Commonwealth of Massachusetts); Harry Shlomer ran a fine hospital; Maida Solomon co-wrote with her husband *Syphilis of the Innocent*, a ground-breaking study of afflicted children—incidentally, both names appeared on the title page; and I'm sure Dr. Cohen was a first-rate resident. Nepotist? Paternalist? You bet. My father was both. And more.

Eric Solomon
professor of English & former provost, San Francisco State University

From the Archives

In the Winter 1989 edition of the *Bulletin*, Amalie M. Kass documented the life and contributions of a remarkable woman ("Harriet Ryan Albee: Charity Begins at the Channing Home"). Since that time her brilliant husband, the late Edward H. Kass, has been succeeded by Dennis Kasper as William Ellery Channing Professor and head of the Channing Laboratory. The Harriet Ryan Albee Chair is now occupied by Elliott Kieff, MD.

In the early and middle '50s, the decline of tuberculosis in response to newer therapy emptied county sanatoria and presented a problem for the Channing Home, a 30-bed hospital for women on Pilgrim Road opposite the Deaconess Hospital. One of the two wards was converted to male occupancy, and at least one HMS student was admitted. However, the writing was on the wall and the directors realized that the home must close as a care facility.

As president, I was authorized to negotiate with Boston hospitals as to which of them might agree to admit tuberculosis patients. None was interested, but the ever-creative associate dean for financial affairs, Henry C. Meadow, approached me with the idea that a laboratory for infectious diseases could be established under the direction of a rising investigator. Edward H. Kass, with his charm, enthusiasm and ability to drink tea with the old folks on our board, as well as his sensitivity to the traditions of the Channing Home, offered an attractive proposal that carried the day. The Channing Laboratory rose at BCH, the Channing chair was established, and many scientific contributions have brought realization to Mr. Meadow's insight and foresight.

With the resurgence of TB among victims of AIDS and drug addicts, it seems appropriate to evoke the memory of Harriet Ryan Albee and the beginning of the Channing Home.

Henry F. Allen '43 t

Pulse

Home Again

As it turned out, the departure of Michael Rosenblatt '73 from HMS eight years ago was a temporary one. Rosenblatt left his position as chief of the Endocrine Unit at Mass. General Hospital to become vice president of biological research at Merck Sharp & Dhome Research Laboratories. But recently he returned to HMS as the first Robert H. Ebert Professor of Molecular Medicine, co-director of the Harvard-MIT Division of Health Sciences and Technology (HST), and director of Beth Israel Hospital's newly established Bone and Mineral Metabolism Division.

Says Rosenblatt, "When I left, there was a wider gulf between industry and academia. I'm sure some people wondered why I did it, but I'd been a consultant with Merck and I knew the quality of its activities. The move, for me, turned out to be very similar to starting medical school or becoming an intern—it fostered immense intellectual growth."

Rosenblatt's research interests began with the parathyroid hormone when he was in the laboratory of John Potts, now HMS Jackson Professor of Clinical Medicine and chief of medicine at MGH. That led to devising a parathyroid antagonist in his own lab and, when he moved to Merck, to studies of a parathyroid-like hormone, which binds to the same receptor and causes the same rise in serum calcium—now called parathyroid hormone-related protein, or PTHrP. He continues research at HMS to elucidate the new hormone's role in normal body functioning.



Michael Rosenblatt

His interest in osteoporosis began at Merck, where he established an osteoporosis research program that has now brought a drug into Phase III trials. This drug, trade named Fosamax, inhibits the action of osteoclast cells that are responsible for bone resorption. At Beth Israel he will continue studies of how osteoclasts attach to bones. He will also be recruiting endocrinologists to carry out basic and clinical research for the BIH Bone and Mineral Metabolism Division.

As for the HST program, says Rosenblatt, "This is an extrememly exciting time to be training people for careers in biomedical research....The joining of medicine and technology will definitely lead to major benefits for human health." He shares the direction of the HST program with Roger Mark, MD, PHD.

The HST program, in fact, is one of the legacies of former HMS Dean Robert H. Ebert, who in 1967 established with MIT president Jerome Weisner this educational and research collaboration. Ebert was also dean when Rosenblatt attended medical school. So Rosenblatt is especially "thrilled and honored" to hold the Robert H. Ebert Professorship in Molecular Medicine, which was established three years ago from gifts of friends and associates, including the Squibb Corporation, on whose board Ebert served for 11 years.

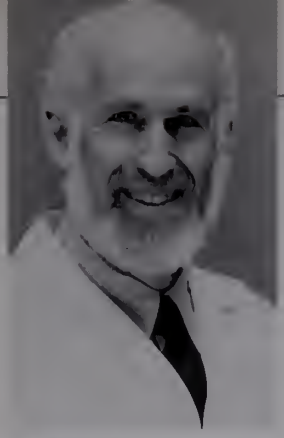
New Chairs

First incumbents have been named this spring to three new endowed professorships at HMS. *Jerome Groopman* is the Dina and Raphael Recanati Professor of Immunology, *Gerhard Wagner* is the Elkan Rogers Blout Professor of Biological Chemistry and Molecular Pharmacology, and *Nicholas Tilney* has been appointed the Francis D. Moore Professor of Surgery.

Jerome Groopman, chief of hematology and oncology at New England Deaconess Hospital, has been at the forefront of the battle against AIDS since the early 1980s. At that time he was an assistant professor of medicine at UCLA and a cancer specialist with research interests that included cancer-associated viruses such as the HTLV retrovirus. He came to HMS and the Deaconess in 1983, becoming head of the department in 1985, and has built widely respected clinical and research programs for people infected with HIV.

Raphael Recanati, an international shipping and banking executive, and his wife, Dina, a sculptor, are major supporters of education, medicine and the arts. Their funds also helped establish the William V. McDermott Professorship, held by Glenn Steele, and have supported the research of George Blackburn, HMS associate professor of surgery.

Gerhard Wagner, PHD, head of the HMS Nuclear Magnetic Resonance facility, has played a key role in developing methods for determining protein structure by NMR. His goal is to better understand the way protein function is determined by structure, how regulatory proteins interact with genes, and how enzymes control cellular processes. Lately he has been push-



Jerome Groopman



Nicholas Tilney and Francis Moore

photo by Barbara Stener

ing the limits of NMR spectroscopy in order to detail the structure of increasingly larger and more complex proteins.

Wagner's professorship is one of two endowed in honor of Elkan R. Blout, PHD, DSC, the Edward S. Harkness Professor of Biological Chemistry and Molecular Pharmacology, Emeritus. The Elkan R. Blout Professor of Biological Sciences at Harvard School of Public Health is Edgar Habar, MD, who is returning to Harvard also as director of the new HSPH Cardiovascular Research Center. As for irrepressible Blout himself, he is on to another arena, as a senior advisor for science at the U.S. Food and Drug Administration.

The other new professorship honors another formidable figure on the Harvard Medical campus: Francis D. Moore '39. Nicholas Tilney, once a surgical resident under Moore and now the director of the Renal Transplant Program at Brigham and Women's Hospital and of the HMS Surgical Research Laboratory, is the first Moore Professor of Surgery. Tilney's research since the 1960s has been on characterizing and preventing the host immune response of rejection of transplanted organs. He was responsible for much of the early characterization of cyclosporine and pioneered its clinical use in 1978. More recently he has been involved in studies of chronic rejection and the cellular products that contribute to this process.

As for the namesake of Tilney's chair, "He has personified surgical science for half a century," says John Mannick, Moore's successor as Mosely Professor and surgeon-in-chief at Brigham and Women's Hospital. Moore was only 34 years old when he received those dual appointments in 1948, and during his 28-year tenure, he became a foremost researcher into metabolic disorders of surgery and influenced a generation of surgeons. Students and colleagues have called him a "great expositor" and a "spellbinding lecturer." He was a one-time president of the American Surgical Society, recipient of the Bigelow Medal of the Boston Surgical Society, and former book review editor of the *New England Journal of Medicine*.

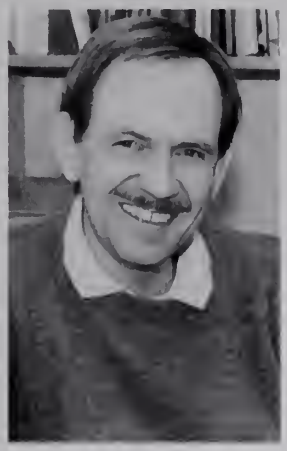


photo by Barbara Stener

Gerhard Wagner

A Day Well Matched

This is a triumphant year for the Class of 1992. "These students have so much talent and have worked so hard," said Edward Hundert '84, associate dean for student affairs. "It's wonderful to see them get rewarded with the opportunity to train at the nation's best hospitals and residency programs."

According to Hundert, the residency preferences of HMS students reflect a national trend toward careers in subspecialties. "The number of students placed in general surgery programs is nearly double that of each of the last few years," says Hundert, "and internal medicine residencies are at a 10-year low."

The Class of 1992's career decisions were made easier, however, through meetings with the newly-formed Academic Societies Committee on Careers, chaired by Hundert.

Graduates and their intended specialties are:

ANÆSTHESIA

Dominguez, Eric
Duke University Medical Center, NC

Regas, Frances
Massachusetts General Hospital

Salant, Evan
Massachusetts General Hospital

EMERGENCY MEDICINE

Burstein, Jonathan
Stony Brook Teaching Hospitals, NY

Lee, Dara
Boston City Hospital

FAMILY PRACTICE

Chaffee, John
Family Medicine Program, Spokane, WA

Fleischman, Joan
Montefiore Medical Center, NY

MEDICINE

Alexis, Jeffrey
Massachusetts General Hospital

Pulse

Aronson, Louise
University of California/San Francisco

Barsotti, Martitia
University of California/San Francisco

Bogan, Jonathan
Massachusetts General Hospital

Campo, Rafael
University of California/San Francisco

Chamberlain, Sherman
New England Deaconess Hospital, MA

Dang, Nam
Massachusetts General Hospital

de Lemos, James
University of Texas Southwestern Medical School/Dallas

Deykin, Aaron
Brigham & Women's Hospital, MA

Dubin, Daniel
Massachusetts General Hospital

Duke, Daniella
Brigham & Women's Hospital, MA

Gaberman, Jonna
Brigham & Women's Hospital, MA

Grazette, Luanda
Massachusetts General Hospital

Haley, Deborah
University Hospital/Boston

Herschenfeld, Rachel
Brigham & Women's Hospital, MA

Jenkins, Timothy
Massachusetts General Hospital

Karchmer, Tobi
University of Washington Affiliates/Seattle

Laufgraben, Marc
Brigham & Women's Hospital, MA

Lee, Lawrence
Beth Israel Hospital, MA

Lowe, Robert
Brigham & Women's Hospital, MA

Lualdi, John
Brigham & Women's Hospital, MA

Marciniak, Robert
Massachusetts General Hospital

Moy, Marilyn
Beth Israel Hospital, MA

Murakawa, George
University of California/San Diego

Plauth, Anna Earl
Brigham & Women's Hospital, MA

Quintana, Rubencio
Kaiser Permanente Medical Center, CA

Raymond, Gregg
Beth Israel Hospital, MA

Remmler, Saiya
Cambridge Hospital, MA

Rhatigan, Joseph
Brigham & Women's Hospital, MA

Rokos, Ivan
New England Deaconess Hospital, MA

Rutledge, Tanya
Hospital of University of Pennsylvania/Philadelphia

Shah, Samir
Beth Israel Hospital, MA

Thompson, Jennifer
Walter Reed Memorial Hospital, Washington, D.C.

Troccoli, John
Boston City Hospital

Trookman, Nathan
Yale-New Haven Hospital, CT

Wu, Thomas
Stanford Affiliated Hospitals, CA

MEDICINE-PEDIATRICS

Ferris, Timothy,
Massachusetts General Hospital

Sinha, Anashua
Massachusetts General Hospital

NEUROLOGY

Elkind, Mitchell
Massachusetts General Hospital

Goldszmidt, Adrian
Harvard Longwood Program, MA

Johnston, S. Claiborne
University of California/San Francisco

McIntire, Steven
University of California/San Francisco

NEUROSURGERY

Arndt, David
University of Maryland/Baltimore

Goradia, Tushar
University of California/Los Angeles

Nguyen, Ben
University of California/Los Angeles

Park, Joan
Brigham & Women's Hospital, MA

OB/GYN

Chen, Annette
Brigham & Women's Hospital, MA

Graham, Scott
University of Colorado School of Medicine/Denver

Hopkins, Frederick
University of New Mexico Program, Albuquerque

Jacoby, Alison
Tufts University Affiliated Hospitals/Boston

Kwok, Charlene
Brigham & Women's Hospital, MA

Rogers, Rebecca
University of New Mexico Program/Albuquerque

Tarquino, Mario
Brooklyn Hospital-Caledonian Hospital, NY

OPHTHALMOLOGY

Brazzo, Brian
Manhattan Eye, Ear & Throat, NY

Burnstine, Michael
University of Michigan/Ann Arbor

Chang, Warren
Wills Eye Hospital, PA

Friedman, David
Wills Eye Hospital, PA

Friedman, Neil
New York Eye and Ear, NY

Kaiser, Peter
Massachusetts Eye and Ear Infirmary

Reynolds, Dale
University of California/San Francisco

Tanaka, George
California Pacific/San Francisco

Tong, Lucene
University of Southern California/Los Angeles

ORAL SURGERY

Kung, David
Massachusetts General Hospital

ORTHOPEDICS

Brown, Gregory
University of Minnesota Hospital & Clinics/Minneapolis

Chu, Constance
University of California/San Diego Medical Center

Duff, Gregory Paul
University of North Carolina Hospitals Program/Chapel Hill

Kim, Thomas
Thomas Jefferson University, PA

Kovach, Ian Shand
University of Texas Health Science Center/San Antonio

Murrey, Daniel
Vanderbilt University Program, TN

Page, Alexandra
Hospital for Special Surgery, NY

Spak, James
Harvard Combined Orthopedics Program, MA

Taylor, Brett
Harvard Combined Orthopedic Program, MA

Tannenbaum, Darryl
University of Michigan/Ann Arbor

Von Deck, Mercedes
New England Medical Center, MA

Watson, Elizabeth
Harvard Combined Orthopedics Program, MA

OTOLARYNGOLOGY

Boyd, Charles
University of Michigan Hospitals/Ann Arbor



photo by Barbara Steiner

Above: Luanda Grazette will be heading to Mass. General.

Kieff, David
Massachusetts Eye and Ear Infirmary

Utley, David Scott
Stanford Affiliated Hospitals, CA

PATHOLOGY

Yang, Jane
Massachusetts General Hospital

PEDIATRICS

Bauman, Carla
Children's Hospital, MA

Cameron, J. Scott
Children's Hospital, MA

Dell, Michael
Children's Hospital, PA

Elisha, Joseph
UCLA Medical Center/Los Angeles

Elmer, Laura
Wilford Hall Medical Center, TX

Han, Linda
Massachusetts General Hospital

Higuchi, Leslie
Children's Hospital, MA

Hoffman, Ben
University of Washington Affiliate/Seattle

Irwin, Meredith
Children's Hospital, MA

Kahn, Jessica Spira
Children's Hospital, MA

Kay, Diane
Children's Hospital, MA

Kim-Hoffman, Jane
University of Washington Affiliate/Seattle

Lerner, Deborah
St. Louis Children's Hospital, MO

Lohrmann, Ute
University of Washington Affiliate/Seattle

MacRae, Katherine
Children's Hospital, PA

Moore, Paul
Children's Hospital, MA

Patel, Rita
Children's Hospital, MA

Powell, Andrew
Children's Hospital, MA

Schizer, Miriam
Children's Hospital, MA

Silverman, Valerie
Children's Hospital, CA

Wu, Yvonne
University of California/San Francisco

PSYCHIATRY

Bolton, Sara
McLean Hospital, MA

Brodkin, Edward
Yale-New Haven Hospital, CT

Cassidy, Linden
McLean Hospital, MA

Heller, Michelle
Cambridge Hospital, MA

Kadish, Deborah
McLean Hospital, MA

Lesser, Susan
McLean Hospital, MA

Rucker, Carol
Alton Oschner Foundation, LA

Simon, Naomi
Presbyterian Hospital, NY

Smoller, Jordan
McLean Hospital, MA

RADIATION ONCOLOGY

Hartford, Alan
Massachusetts General Hospital

Proulx, Gary
Massachusetts General Hospital

RADIOLOGY

Clark, Kelly Anne
University of California/San Francisco

Hartman, Audrey
Beth Israel Hospital, MA

Iaia, Alberto
Brigham & Women's Hospital, MA

McKinstry, Robert
Barnes Hospital, MO

Rivera, Michelle
Duke University Medical Center, NC

Suchin, Craig
Massachusetts General Hospital

REHABILITATION

Standaert, Christopher
University of Washington Affiliate/Seattle

RESEARCH

Yu, Debra
Food and Drug Administration, MD

SURGERY

Abnet, Kevin
Massachusetts General Hospital

Ashiku, Simon
Massachusetts General Hospital

Bullard, Kelii M.
University of California/San Francisco

Cabaltica, Rex B.G.
Walter Reed Memorial Hospital,
Washington, D.C.

de la Torre, Ralph
Massachusetts General Hospital

Dunn, James
UCLA Medical Center, CA

Epstein, Stephen
Beth Israel Hospital, MA

Farber, Alik
Massachusetts General Hospital, MA

Glasson, Julie
Stanford Affliated Hospitals, CA

Glenn, David
New England Deaconess Hospital, MA

Han, David
Emory University School of Medicine, GA

Hopkins, Mary Ann
New York Hospital/Cornell Medical
Center Program

Huang, George
University of Washington Affiliate/Seattle

Hudlin, Margaret
New England Deaconess Hospital, MA

Juarez, Gregory
Cedars-Sinai Medical Center, CA

Kallin, Kristopher
University of California/San Diego
Medical Center

Kang, Sang-Mo
University of California/San Francisco

Kim, David
Barnes Hospital, MO

Lee, Vivian
Duke University Medical Center, NC

Pechet, Taine
Brigham & Women's Hospital, MA

Pulse

Perez, Martin
New York Hospital/Cornell Medical Center Program

Quinn, Theresa
University of California/San Francisco

Rago, Oscar
Barnes Hospital, MO

Sarosi Jr., George
University of Michigan Hospitals/Ann Arbor

Tran, Nam
University of Texas Southwestern Medical School/ Dallas

Winograd, Jonathan
Johns Hopkins Hospital, MD

UROLOGY

Comiter, Craig
Harvard Medical School Program, MA

Daitch, James
Cleveland Clinic Foundation, OH

Harmon, Keith
The Mount Sinai Medical Center, NY

Hughes, Richard
Hospital of the University of Pennsylvania

OTHER

Dorsey, Cheryl
Program Director/The Family Van, MA

Biomedical Science Careers Conference

"Many minority students are missing the opportunity for a career in biomedicine simply because they don't know what support is available to them," says Joan Reede, MD, director of the Minority Faculty Development Program at Harvard Medical School.

To help minority students discover career and funding opportunities, the Minority Faculty Development Program, the Massachusetts Medical Society and the New England Board of Higher Education co-sponsored the Biomedical Science Careers Conference March 13 and 14 at the Boston Park Plaza Hotel. Participants included foundation representatives, college administrators, leaders in biomedicine and 280 black, Hispanic and Native American students from New England high schools, colleges, graduate schools and professional schools.

Minority groups make up 21.8 percent of the population, but they only represent 10.4 percent of medical students. For the past 17 years the number of minority students in American medical schools' first-year classes has remained stagnant, and minorities make up less than 3 percent of medical school faculty.

Minority representation is somewhat higher at HMS: 14.9 percent of medical students and 4.1 percent of faculty members. The Minority Faculty Development Program was created in May 1990 to serve as an umbrella for all minority recruitment, development and retention initiatives undertaken at HMS and its affiliated hospitals.

The conference was developed to foster the creation of more mentoring programs to encourage minority students to pursue advanced degrees in biomedicine, explained Reede. Students had the opportunity to meet with 44 minority role models from the sciences, medicine, nursing and academia, as well as to participate in workshops in biomedical career opportunities, career goal-setting, funding sources and future trends in biomedical sciences. Donald Wilson, MD, dean of the University of Maryland Medical School and the first black dean of a nonminority medical school, and Vann Dunn, MD, a senior health policy advisor for Senator Edward Kennedy on the Committee on Labor and Human Resources, delivered keynote addresses. Both speakers stressed the importance of determination and mentoring for minority students.

The Biomedical Science Careers Conference was preceded by another Minority Faculty Development Program-sponsored conference, Foundations and the Future of Minority Biomedical Education, on March 13. Representatives from seven major educational funders presented reports on successful projects to bring minority students into medical and scientific careers. Afternoon workshops focused on recruitment, mentoring, program linkage and attrition in high school, college, medical and graduate school. The conference was co-chaired by Harold Amos '43A, Presley Professor of Microbiology and Molecular Genetics Emeritus, and Clifford Barger '43A, Pfeiffer Professor of Physiology Emeritus.



Left:
Attendees at the biomedical conference

Under New Management

Many employees wish they could tell the boss how to run the place. A new "participatory management" plan adopted at Beth Israel Hospital two and one-half years ago not only allows employees to offer their two-cents worth, but motivates them to do so. Under the Scanlon Plan, named after its developer, employees are charged with creating solutions to problems in their work areas; in response, management works with employees to implement their good ideas.

All the hospital's employees, from the physicians to radiology techs to kitchen staff, participate in interdepartmental work teams whose objective is to solve problems within their areas of involvement and competence. Every employee belongs to at least one team. Some teams assemble only long enough to solve a particular problem; others are integral to long-term planning and thus meet regularly over long periods of time. The BI calls its version of the program "PREPARE/21" (Participation, Responsibility, Education, Productivity, Accountability, Recognition, Excellence...for the 21st century), or P/21.

In addition to their team efforts, employees are encouraged to submit suggestions individually. Over 500 ideas were submitted in 1990, the plan's first year, about half of which were implemented. Ways to solve problems of inefficent CT-scan scheduling and missing IV medications were among the suggestions. Work teams then design and carry out projects to address the problem.

An example of the results of a work team approach was the creation of a pharmacy satellite in the operating room/post-anaesthesia care unit. Before P/21, separate drug inventories existed in the surgical suites, post-anaesthesia care unit, and ambulatory surgery area. This lack of centralization led to wasted inventory and difficulties in tracking usage and handling billing. A work team made up of staff from the departments of pharmacy, anaesthesia, and critical care and operating-room nursing designed the satellite solution based on their own experiences of working in their separate areas. The satellite successfully alleviated the confusion and, in addition, increased access to drugs and to drug information.

Mitchell T. Rabkin '55, president of Beth Israel Hospital, says he decided to introduce Scanlon techniques in part to counteract the effects of the economic recession but also to "improve employee morale by creating the opportunity for employees to manage adversity rather than be pushed around by hard times."

Said Laura Avakian, vice president of human resources, in the February issue of *Strategies for Healthcare Excellence* magazine: "We knew we were due for a series of onslaughts, and we wanted to put some processess in place to react to the cold, cruel world, to unify our employees and increase their investment in the hospital's successes."

The plan was formally approved by the Board of Trustees in 1988 and enacted with the opening of fiscal year 1990. An estimated $1 million was saved in fiscal year 1990 as a result of P/21 activities. While the cost savings are appreciated, Rabkin stresses that "the primary focus is quality in everything we do: the systems by which we deliver patient care, and ultimately patient care itself."

Employee "gainsharing," whereby employees share in the savings attributed to their participation in meeting the goals of the hospital, is another element of P/21. So is an employee education and information component: an array of internal publications, including two written by Rabkin, discuss financial issues, environmental concerns and other matters of hospital business. Each issue of the *BI Examiner*, the employee newspaper, features write-ups of successful work team projects and ideas from individuals.

Rabkin admits that although they are pleased with the success of P/21, the plan will "take time to become part of the intrinsic woof and warp of the hospital fabric." Rabkin says that physicians have been the slowest to embrace P/21, as they tend to think less in organizational terms. "As they have seen the results, however, they can appreciate its effectiveness and have become more involved," he says.

The Scanlon Plan, developed in the 1950s by former steelworker and later MIT lecturer Joseph Scanlon, stresses three factors: educate employees about the organization; empower and enable employees to "own the problems" of improving the organization and commit to making positive change; and return to employees the equity they deserve for investing in the organization.

The BI is the first hospital, and the first nonprofit, to incorporate Scanlon's plans. It is also the largest employer, with 4,800 employees, to use the plan. Rabkin and BI management adopted the Scanlon Plan after visiting Herman Miller, Inc., a furniture manufacturer in Michigan that had achieved markedly increased productivity using Scanlon's ideas.

Partially in response to other hospitals' inquiries into the plan's effectiveness, Rabkin and Avakian have written about P/21 for an upcoming issue of *Academic Medicine: The Journal of the Association of the American Medical Colleges*.

On the Quadrangle

Something New

The medical school has shared space with concrete mixers and other heavy machinery for the past couple years, and among the results is a state-of-the-art biomedical facility. Temporarily called the East Quadrangle Research Facility, this building is a bold new element in a master plan to retain and attract the finest in research and instructional staff possible to Harvard Medical School.

The EQRF was conceived following an assessment of existing buildings, which led to the development of a plan to enhance and expand educational space and research facilities. The Medical Education Center, a contemporary setting for learning, was completed in 1987 with that first goal in mind. A 500-space parking garage was built under the Quadrangle, Vanderbilt Hall was restored, and renovations completed on Buildings A through D. And now, the EQRF expands the school's laboratory space and provides researchers the most state-of-the-art technology available, in an open and collegial environment. Ground was broken in March 1990, and occupancy of the new $59 million, five-story building will begin in July of this year.

Moving into the new EQRF will be the Department of Neurobiology, headed by Gerald Fischbach, Nathan Marsh Pusey Professor of Neurobiology; and the Department of Genetics, chaired by Philip Leder '60, John Amory Andrus Professor of Genetics. The Center for Blood Research, headed by Fred Rosen, the Gamble Professor of Pediatrics, will expand from its Huntington Avenue location to the first floor of the new building. A small-animal facility, directed by Arthur Lage, DVM, will be housed in the facility's basement.

The building itself is the product of studies and research on what constitutes optimum design for scientists' work spaces. When designing the lab areas, architects Davis, Brody and Associates of New York City considered the human aspects of how people function and interact in a laboratory environment and the necessary space requirements for that. "We designed the building by thinking first about its function," says Norman Neiterman, director of major projects at the medical school, "and then we put a shell around it."

It is this attention to infrastructure that will enable the facility to maintain long-term viability. The building was designed to be flexible to future changes and adaptations. For instance, the location of fume hoods, sinks and walls can be changed readily without major construction, or expense.

Floor plans were designed with human interaction in mind: a racetrack corridor runs the length of the building, with offices and bench spaces on the outside and lab support spaces on the inside that open on each side. The result is all the laboratories feel connected, and people move towards each other—as opposed to away from each other down linear hallways. A glass-roofed indoor courtyard on the ground floor, between Buildings B and D and accessible from the Quadrangle, will provide food service and seating for lounging and special events.

The EQRF's exterior, which faces Longwood Avenue and sits behind but interconnects with Buildings B and D, is designed to integrate with the 1906 marble facades of the existing buildings, and yet present an independent theme. The structure also acts as a linkage between Buildings B and D, which before had been isolated from each other. With the EQRF as a conduit, floors from all three buildings are now connected.

A scientific symposium and convocation to celebrate the dedication for the EQRF is planned for September 11, 1992.

Terri L. Rutter

Tight Budget

Like all of us, Harvard Medical School has been affected by this period of economic recession. "If we don't take action now, and continue to allow our expenses to grow, we'll find ourselves in significant deficit," points out John Deeley, administrative dean for financial affairs.

The deficit projected for the current fiscal year that ends June 30 is $2 million, and could be $6 million next year. To prevent this, HMS has completed a long-range financial plan that incorporates program changes, faculty recruitment, and inflationary increases for the next five years.

The medical school's main objective is to maintain the momentum of the initiatives that have been under way for the past five years, says Deeley, and to support the commitments made to faculty who have been and will be recruited. Plans are to complete the renovation of the Quadrangle buildings, to renovate Countway Library and enhance its programs, and to recruit 65 faculty members over the next five years (both replacements and additions).

The school has come to the point of deficit by a confluence of the general economy, expenses for the building and renovation, and the federal government's cutbacks on reimbursement for the indirect costs related to research.

To maintain the momentum deemed necessary to uphold the school's preeminence in research and education necessitates a fiscal plan as striking as any of the new building plans. According to Deeley, the school's strategy is to:

Book Marks

•

Restriet growth of base operating budgets to sub-inflationary increases.

•

Implement program budgeting into the annual budget approval proeess; that is, evaluate departmental programs and priorities with resourees allocated.

•

Develop strategies to inerease support for research from the corporate sector.

•

Press for more fair reimbursement for the indireet eosts of researeh from federally-sponsored researeh.

•

Foeus future fundraising priorities on raising current-use funds.

•

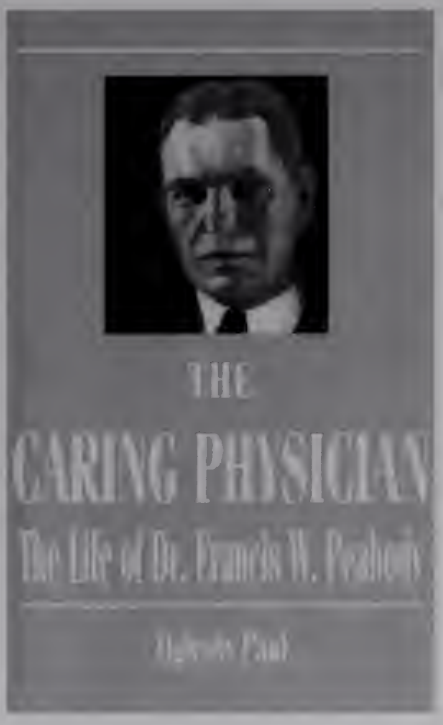
Reduee administrative eosts by $2 million to offset the government's reduetion of support for administrative eosts of researeh. "The approach is to identify administrative operations and processes that we can streamline, or to eliminate redundaneies," says Deeley.

A steering committee of senior administrators has been appointed to develop the strategy to accomplish this goal. They expect to eliminate about 40 positions, or 10 percent of the HMS administrative staff.

Though it costs about double the tuition—next year is about $20,250—to educate a medical student, it is expected that future tuition increases will be held to a rate no higher than inflation. Financial aid packages will not be affected by the cutbacks in administrative costs.

But belts are tightening at HMS. "Strategies are in place and we will deal with our deficit," says Deeley, "while maintaining our preeminence in education and research."

Ellen Barlow



THE CARING PHYSICIAN:
THE LIFE OF DR. FRANCIS W. PEABODY
by Oglesby Paul
(Francis A. Countway Library of Medicine, 1991).

by Guillermo C. Sanchez

"The secret of the care of the patient is in caring for the patient." For many years the entering elasses at Harvard Medical School have been made aware of this aphorism—the conclusion and central message of "The Care of the Patient," a crucial essay by Francis Weld Peabody '07. More recently, a segment of each class has belonged to the Peabody Society, named in his memory. These students look up at his portrait every day as they visit their society's headquarters. But how many of these same students and recent alumni are aware of a great many other contributions by Peabody?

Oglesby Paul '42, professor of medicine, emeritus, has written a detailed biography that should clarify and define Peabody's life and work, and his lasting impaet on the eminent physieians whom he trained, their students, and their students' students. The book, handsomely published by the Countway Library, ineludes an opening ehapter on Peabody's aneestors and beeomes increasingly detailed as it deals with his medieal studies, his postgraduate training, his mentors and their highly appreeiative eomments on his elinieal and researeh aecomplishments.

The text quotes eopiously from letters and posthumous eulogies. Three essay-leetures are reprodueed in toto: from 1922, "The Patient and the Man"; from 1927, the longer, deeper and more thoughtful "The Care of the Patient"; and the artiele deseribing elinieal observations on himself, "Notes on the Effects of Morphine," completed only one day before his death. A complete bibliography of Francis W. Peabody's articles is appended.

Franeis Peabody was born in Cambridge in 1881, the son of Cora Weld and the Reverend Francis Peabody, who was the eighth of that name on these shores and the Professor of Christian Morals at Harvard. The younger Peabody was a nephew by marriage of Harvard's greatest president, Charles Elliot.

In his teens, the boy was serious, quiet and a far-from-sparkling student at the Browne and Nichols School. He graduated at 16 and went abroad with his parents for a second, long journey through Europe and Egypt. In Constantinople, they were invited to a garden party by the sultan. On their way back, in Florence, Franeis and his brother Derby were struck down by typhoid fever and only Franeis sur-

vived. His family thought that this tragedy was crucial in pointing him towards a medical vocation.

Harvard College next, with much more successful studies, and thence to Harvard Medical School. His postgraduate training followed an ideal path towards a career in academic medicine, in those days an unusual objective: MGH, Johns Hopkins, the University of Berlin in chemistry, the Rockefeller Institute and the Peter Bent Brigham Hospital.

At the Rockefeller, Peabody was in charge of patients during an epidemic of poliomyelitis, and he earned glowing praise from the director, Simon Flexner, MD. Before joining the new Brigham as chief resident physician, Peabody toured Europe with Henry Christian, MD, exploring the most recent developments in hospital construction and management. Copenhagen with August Krogh, MD was probably the most fruitful stopover, and St. Petersburgh the most exotic.

Peabody's stay at the Brigham was interrupted by a long visit to China, under the auspices of the Rockefeller Foundation, to evaluate Chinese medical education and hospitals, 88 of them. In 1917, he was invited to join a Red Cross group designed to evaluate the medical needs of devastated Romania, which they reached by traveling 52 days across the Pacific and Russia. The Bolshevik Revolution caught them in Moscow, where they were under fire as they tended the wounded for two weeks before entraining back to Peking.

Military service with the U.S. Army in France followed, and on his return, two crucial and happy events occurred: his marriage to Virginia Chandler, and his appointment as professor of medicine at Harvard and chief of the new Thorndike Memorial Unit at Boston City Hospital. He accepted this position in preference to many other offers of professorships or deanships, including at Chicago, Johns Hopkins, Michigan and Shanghai and, Paul surmises, probably Columbia, Yale and Stanford.

When John D. and Sharon Rockefeller Jr. embarked for China for the inauguration of Peking Union Medical College, they invited the Peabodys to join them. As Virginia Peabody later recounted to me, the young couple, wanting to be proper, dressed for dinner the first night out, only to discover that the elderly Rockefellers were dressed informally. Attempting to correct their mistake, the Peabodys were informal the next day and found the Rockefellers in evening clothes then and on all subsequent evenings.

Sunday lunches and teas at the Peabodys' house must have been charming respites for the staff, house staff and students of the Thorndike. His wife was one of the greatest hostesses of Boston, as I and many others, who in later years were the recipients of her glowing hospitality and kindness, can attest. Rene Dubos, not a man given to lyrical speech, described her as a "fairy queen" as she descended the stairs to greet her guests. In those years, the young visitors included many who themselves reached the status of medical giant: Soma Weiss, Joseph Wearn '17 and William Castle '21, among them.

The brilliant years of the Thorndike under Peabody were all too brief. Much important research was produced there, especially on blood disorders and nutrition. In 1925 Dean Edsall, in words reminiscent of our New Pathway, initiated a series of lectures "to present to the student the simpler, human, psychological aspects of medical practice." The third lecture was "The Care of the Patient," presented by Francis Peabody. The subject absorbed Peabody over the next two years until his untimely death in 1927, and culminated in the lecture and essay referred to at the beginning of this review. Not long before his gallant death of cancer at 46, he remarked to Virginia that it was ironic that this contribution appeared likely to survive far longer than his many scientific endeavors.

In this biography, Oglesby Paul covers all of Francis Peabody's professional accomplishments and background with an approach that will give medical readers much to wonder at and much to admire. One might wish, however, for more on Peabody the man: what made him tick, why so relatively suddenly he developed the new orientation of his interests; and what, in a very personal way, he felt about his illness.

Peabody's colleague Hans Zinsser wrote of him: "One gathers only wonder at the inner symmetry of intelligence and heart which made his life a blessing and his death an inspiring lesson." His childhood friend Langdon Warner added about his last days: "In a direct manner we partook of the amazing experience through which he was passing...we shared in the ultimate victory. We heard sentence delivered and saw him, neither defiant nor stricken by it, walk on in his accustomed way."

Guillermo C. Sanchez '49 is HMS assistant clinical professor of medicine and a member of the editorial board of the Harvard Medical Alumni Bulletin.

Campaign Report

"I promised you a party and this is it!" said Dean Tosteson as he welcomed close to 350 people to the Copley Plaza Hotel on March 6 to celebrate the successful conclusion to the Campaign for the Third Century of Harvard Medicine.

The five-year campaign raised an unprecedented $191,134,000 for the medical and dental schools, exceeding the goal of $185 million—a goal, pointed out the dean, that "more than a few skeptics felt couldn't be done." Funds raised have already been used to support the school's research and educational programs, endow professorships, establish scholarships and student loans, and to help build the Medical Education Center and renovate Vanderbilt Hall and the buildings on the Quadrangle.

Joining the dean at the dinner-dance celebration were members of the National Campaign Committee, National Alumni Committee, the Third Century Fellows, class agents and other medical school "friends." Neil Rudenstine, president of Harvard University, extended greetings and congratulations, and commended the dean and everyone at the medical school for the exciting things being done.

The dean paid special tribute to the late Colman Mockler Jr., who as co-chairperson of the campaign provided "dynamic and thoughtful leadership," but "whose untimely death early last year saddened all of us who knew him." The other co-chair, Lewis Thomas '37, was also cited, as was Ellen Gordon, president of Tootsie Roll Industries, who stepped up from the ranks of the National Campaign Committee to finish the campaign as co-chairperson. Gordon made a toast to the future of HMS, and told celebrants: "HMS is a reminder...that tomorrow can be more healthful than today."

To achieve such an ambitious goal, Dean for Resources William Stone pointed out that it required the commitment of many "to help the school preserve and build its commanding position in American and world medicine."

Over 125 alumni and other friends of the school served on national campaign committees (the alumni effort was headed by Perry Culver '41 and Daniel Federman '53), and 500 alumni served on 17 regional committees. Over $50 million came from alumni, "a truly remarkable outpouring of gifts," said Stone.

There was plenty of dancing, good food, and thank-yous all around. "Because of you, the campaign has been successful," said the dean in closing. "We have gotten to meet and revive old friendships with so many wonderful people, and although I never would have believed it, it has truly been fun."



photos by Marjorie Siegel

Magdalena Tosteson, Harvard President Neil Rudenstine, and Joseph Murray '43B, chairman of the Alumni Fund.



HMS Dean Daniel Tosteson '48 dances with Ellen Gordon, co-chair of the campaign.



Cliff Barger '43A and Claire Stiles '56.



Perry Culver '41 and Daniel Federman '53, co-chairs of the National Alumni Committee.





photo by Jerry Bernat

Every Day Another Wound

by Paul Farmer

A short and affecting poem by Jean Metellus, a prolific writer who also happens to be a physician, captures neatly the ongoing catastrophe that is rural Haiti. The poem is called "No Reprieve," and it ends with the following lines:

...the earth I worked yesterday
The earth still stuck to my face
The dirt I plowed
Went off with the last downpour
Carrying songs and seeds to the sea
And now not even a caterpillar would
willingly live under my feet
The fields' teeth have chewed at my
patience
And my breath is as fragile as a flower

I am writing this in rural Haiti, a place where the fields do indeed have teeth, teeth that each year grow sharper and longer as more and more topsoil is washed to the sea. These rural villagers—who call themselves "peasants" even if they do not have much land—are my hosts and have at times seemed strong, and at times, yes, as fragile as flowers.

Left:
Jean Bertrand Aristide, deposed president of Haiti.

I first came to Haiti in the spring of 1983, a fragile enough moment: for 25 years, the country had been held in the vise-like grip of the Duvaliers, and their legacy to the Haitian people was largely one of entrenched misery and repression. A UNICEF study published in 1985 revealed that a Haitian child was then dying every five minutes; a majority of children were malnourished. Poor adults continued to die from infectious diseases long ago brought under control in most other American nations. Life expectancy hovered around 50 years. Patterns of disease and death among the rich minority, on the other hand, were similar to those seen in the United States.

The village from which I now write was possibly even worse off than the rest of rural Haiti. I first visited "Kay" in May 1983, when a Haitian cleric—call him Jacques Alexis—took me to visit a settlement formed by refugees from a hydroelectric dam, erected in 1956. It seemed plausible to assume that, among peasants who had previously tilled a fertile valley, loss of land would lead to substantially increased rates of morbidity and mortality. This impression was borne out by a series of rudimentary studies conducted between 1983 and 1985.

With support from Harvard Medical School, I joined a small group of young villagers in collecting "retrospective death reports" from families in the Kay area. It appeared then that the chief causes of death among infants and children were diarrheal disease complicated by malnutrition, pneumonia complicated by malnutrition, typhoid complicated by malnutrition, and malnutrition. Neonatal tetanus and meningitis were also reported. Among adults, tuberculosis topped the list, followed by typhoid, malaria and complications of childbirth. As we initiated these studies, the last of Haiti's native pigs—indispensable to the rural economy, according to experts—were being exterminated in a swine flu containment program spearheaded by the United States and Canada. It seemed then that the situation could get no worse.

The image of a fragile and beaten-down peasantry was intermittently dispelled by the people who worked with Father Alexis, who still directs a number of community development efforts in central Haiti. For over 40 years, his ministry has been slanted towards social programs: medical care, community organizing, small-scale agricultural projects and, above all, schools for the rural poor. It was thanks toFather Alexis that my coworkers could read and write. In Kay, where there was no fertile land, the priest began training villagers in the arts of carpentry, masonry and design. A construction team was formed, and it erected, during the 1980s, a church, a large elementary school, a dormitory for teachers, a community bakery, a lunchroom, a day care center, a guesthouse, and scores of latrines. Each year more and more houses—most of which were two-room shacks—boasted tin roofs and cement floors. A pig-replacement program was planned.

It was my great privilege to join this team of community activists, most of whom were themselves peasants from the Kay region. As a student of both medicine and anthropology, I

Many Haitians I have known or met are now dead.

was, of course, most interested in helping to inaugurate community health efforts. With the financial support of Tom White, a philanthropist from Boston who had enabled us to build the bakery, we designed and implemented a comprehensive preventive and primary-care program that included vaccination campaigns, prenatal care, malnutrition and tuberculosis eradication programs and AIDS prevention efforts.

By August 1985, Proje Veye Sante (the "health surveillance project") had established services in Kay and four neighboring villages. Just over a year later, nine villages were being served, each with at least one full-time community health worker who was a native of the village. In Kay itself, the capping of a major spring—a project funded by a U.S. sister-diocese—led to a prompt and widely appreciated decline in diarrheal disease among infants.

Nonetheless, hunger and sickness continued to exact a high toll on the population, and suffering was an expected condition. But it was not countenanced silently, and the people of Kay, like Haitians elsewhere, continued their struggle for some measure of justice. By the end of 1985, the entire nation groaned under the corrupt and repressive regime of the Duvaliers.

In November an obscure anti-government protest in the city of Gonaives became the focus of national rage when government forces shot and bayoneted three schoolboys. Over the protests of the children's families, the bodies were buried in an unmarked grave at an undisclosed time: the regime wished to prevent the funerals from becoming anti-government protests. This ploy had, of course, just the opposite effect and soon the nation's students refused to return to school until Duvalier relinquinshed his throne.

I was scheduled to be in Boston in an HMS parasitology class, but January 1986 found me stuck in a Haiti wracked by strikes and brutal repression. One of the many tracts floating around the eerie, abandoned streets of Port-au-Prince caught my eye. It was addressed "To All The Countries Who Contribute Foreign Aid To Haiti": "Do you wish, through your continued support of the Duvaliers, to make Haiti a living laboratory for the study of misery? Why don't you consider these facts: Haiti receives more aid, per capita, than any country; Haiti is right next to the United States, the most developed country on the face of the Earth, and we remain the poorest."

From the vantage point of rural Haiti, the United States did indeed loom large, and so did our lavish support of the Duvalier regime, which each month was diverting millions to Swiss bank accounts. What's more, the other debacles of contemporary Haiti—the appalling poverty, the brutality of the U.S.-trained military, the incarceration of Haitian refugees in U.S. detention centers, the destruction of Haiti's pigs, AIDS (which Haiti was accused of exporting)—did not appear to be "Haitian" problems at all, but international ones.

But prior to the fall of Jean-Claude Duvalier, their significance as such was not widely appreciated outside of Haiti. Only a minority of U.S. citizens were aware of the Reagan administration's harsh interdiction policies regarding Haitian "boat people," and even fewer knew that the Duvalier dictatorship's chief source of foreign exchange had long been the United States government or U.S.-controlled multinational aid. Few North Americans knew that the United States had militarily occupied Haiti for almost 20 years, creating during our

tenure an army that seemed to most Haitians to have but one enemy: the Haitian people.

Stirred in part by continued military and paramilitary (i.e., the "tontons macoutes") brutality, popular sentiment against the dictatorship continued to mount. On February 7, 1986, after a midnight champagne party in the palace, Jean-Claude Duvalier, his entourage, and a great deal of luggage left Haiti in a U.S. cargo plane. Was this to be, at long last, a reprieve in the unremitting suffering of the Haitian people?

The hope awakened in 1986 eventually gave way to great disappointment, as Haitians came to see that there could endure "Duvalierism without Duvalier." The military government—the "CNG"—that took over the state apparatus was more or less appointed by Duvalier, and it was soon clear that far-reaching change was not high on its list of priorities. Demonstrations and strikes were met in classic Duvalierist fashion: with bullets.

Again, these were not purely Haitian affairs. In a penetrating study of contemporary Haiti, anthropologist Michel-Rolph Trouillot put it trenchantly: "By the end of its first year in office, the CNG, generously helped by the U.S. taxpayers' money, had openly gunned down more civilians than Jean-Claude Duvalier's government had done in fifteen years."

The events of this era were experienced by all of those living in villages like Kay. In rural Haiti, the years that followed 1986 were marked not only with hunger and sickness and drought, but with arrests, "disappearances," and massacres (all of which served to underscore the fragility of the Haitian poor). But these were also years of stalwart resistance, a refusal to settle for anything less than "decent poverty," and a burgeoning popular movement (which served, in turn, to accent the strengths of these same people). And lucid analyses could not be entirely drowned out.

Perhaps the clearest voice in the cacophony was that of Jean-Bertrand Aristide, a diminutive but charismatic priest closely identified with liberation theology, a brand of Catholic theologizing that decries the "structural sin" of the oppressive conditions hobbling Latin America. From his pulpit, Father Aristide deplored a social order in which a privileged few feasted, throwing an occasional crumb to the multitudes under the table. He warned against the dangers of Duvalierism with Duvalier. He passionately cried out for satisfaction of "the people's demands." Few then understood just how many Haitians were listening to his message.

We certainly heard Aristide's words out in Kay, where he was widely considered an envoy from above. Although by no means immune to the violence that often wracked urban Haiti, the team here managed to continue to expand our medical projects. Thanks especially to Tom White, Father Alexis and crew were able to build a large and well-stocked clinic



designed to serve the rural poor. One of Alexis's prior students, hailing himself from a two-room hut in a nearby village, became the medical director of the new facility. The staff, which came to include a dozen physicians, nurses and technologists, began to care for a massive wave of previously neglected people.

The community health project continued to expand, as did its staff; by 1989, 16 villages were served by over 20 community health workers. In most of these communities, we were able to document decreases in infant and juvenile mortality. The effects of the clinic were more difficult to gauge, but area residents often credited the doctors with having "saved many cases."

These victories have all too often seemed pyrrhic. There was still no real reprieve for the peasants of the region, and the stark misery of Haiti struck us telling blows. The clinic's first archivist, a brilliant young woman from a town not far from Kay, died of puerperal sepsis contracted in a Port-au-Prince maternity ward. As our medical director, who had known Marie-Ange since they were children together would have it, "the country killed her."

In the space of two months, two more close friends, who had been among the first members of the community health team, also died from infectious diseases: Acephie, 21, of cerebral malaria and Michelet, 23, of complications of typhoid fever. Acephie, then attending school in a large town in central Haiti, had been behaving erratically and was referred to a psychiatrist. She died in his waiting room. Michelet was also away at school—and the clean drinking water of Kay. He perished on an operating table during the course of a too-late intervention to resect his perforated ileum, a complication of typhoid fever.

Acephie and Michelet were both members of the first graduating class of Father Alexis's new elementary school, and two of the first villagers to attend high school. "There are tragedies," said the elderly priest in a memorial service for both of them, "from which one does not ever fully recover."

Demonstrations and strikes were met in the classic Duvalierist fashion: with bullets.

Graduate studies in anthropology had by then sharpened my awareness of the fundamentally social—political and economic—nature of these tragedies. But there were other, more overt expressions of hostility to the poor and their advocates.

The most flagrant of these, in 1987, was the election-day massacre during which scores of voters were hacked to death by paramilitary forces. In 1988 it was the state-sponsored attack on Father Aristide's parish, while he was celebrating Sunday mass, and the death of many worshipers. The church was then torched in full view of the army and police, who clearly approved of the crime. Aristide, who had by then survived several attempts on his life and was considered by many Haitians to be something of a prophet, was shortly thereafter expelled from the Salesian order.

"The crime of which I stand accused," recounts Aristide in his book *In the Parish of the Poor*, "is the crime of preaching food for all men and women."

It is for this reason, clearly, that poor Haitians—the majority, here—voted en masse and with near unanimity for Aristide, who on December 16, 1990 was elected president in the only democratic elections Haiti has ever known. As someone who'd had the great privilege of living among the rural poor, I was of course passionately interested in interpreting one of the first hopeful signs in decades. My coworkers, all of whom are Haitians, were nothing short of thrilled. All of them.

The excitement of the first eight months of 1991 defies description. It seemed that the Haitian poor, contrary to the poem, had finally gotten their reprieve. In spite of mixed reviews in the U.S. and conservative Haitian press, in spite of the slowness with which some promised reforms were instituted, Aristide's standing in the eyes of the rural poor seemed only to grow. Longtime Haiti watchers had the sense of witnessing something altogether unique, (if related to other movements in Latin America) and strongly conditioned by struggles in Haiti's past.

Attempting to describe what was new and how it was related to what was not new appealed very much to the anthropologist in me, as did addressing a series of key questions: How might Aristide's adherence to liberation theology influence his choices as a statesman? How was his victory related to the popular movement in which his candidacy was embedded? What would Aristide be able to do against such long odds? What could anyone—even an envoy from above—do in the face of so much sickness and suffering?

It is not clear that anyone will know the answers to these questions. On September 30, 1991, I was running through the Miami airport to catch a flight to Haiti that would never take off: there had been a military coup early that morning, said the impassive airline representative. The plane was now going to a beach resort in Mexico. Sitting in a Miami motel staring woefully at the television, I learned that Aristide was missing, and that the army was meeting popular resistance, which was considerable, with implacable force. After 36 hours of nonstop CNN, I returned to Boston. (As a research resident in internal medicine

Pas d'échéance

Pas d'échéance pour l'homme tremp dans la parole
Car la vie roule et hurle
Plus folle que l'étreinte de la mort
Plus fiévreuse que les cils du soleil
Elle peut venir demain sursauter dans ma case
Chasser la peine plaquée sur ma peau
Iluminer ma cabane naufragée
Et me faire oublier mon berceau de pluie
Et toutes les rives ruisselantes de mes nuits
Et tout l'espace catarrheux des regards
Mais la terre, la terre, la terre que j'ai labourée hier
La terre qui me colle encore au visage
Ce sol par moi remue
Est parti avec la dernière averse
Emportant chants et semailles à la mer
Et sous mes pieds une chenille n'accepterait pas de vivre
Les dents de la campagne ont rogné ma patience
Et mon souffle est fragile comme une fleur

—Jean Metellus
From *Au pipirite chantant* (1978)

No Reprieve

No reprieve for the man steeped in the word
For life rolls and howls
Crazier than death's embrace
More fevered than the eyelashes of the sun
Life might come tomorrow vaulting into my hut
To chase away the pain caked on my skin
Light up my shipwrecked cot
Make me forget my cradle of rain
And all the rippling banks of my nights
And all the rheumy sweep of glances
But the earth, the earth, the earth I worked yesterday
The earth still stuck to my face
The dirt I plowed
Went off with the last downpour
Carrying songs and seeds to the sea
And now not even a caterpillar would willingly live
under my feet
The fields' teeth have chewed at my patience
And my breath is as fragile as a flower

—translation by Haun Saussy

at the Brigham and Women's Hospital, I had patients waiting.)

Within a few days, after the dust had settled, I learned what had become of my colleagues in Haiti. It could have been far worse, certainly, but it was bad enough. Friends and co-workers had been harassed, arrested and even expelled. One friend was arrested three times, always without a warrant, and eventually sought refuge in an embassy, where he spent more than two months before being granted safe conduct out of the country. It is estimated that over 1,000 lost their lives during the initial stages of the coup.

When at last able to return, in January of this year, I found the situation here nothing short of catastrophic. On one of my first days back, a young man from a neighboring village died from wounds sustained during torture sessions in the nearby military barracks—a horrible sight. His young wife, who had been recovering nicely from tuberculosis, was soon gaunt and coughing again. The villagers were frightened and as fragile as I had ever seen them. No reprieve, indeed, "For life rolls and howls/Crazier than death's embrace."

I have been, over the past decade, continually appalled by the lot of the Haitian poor, who teeter on the edge of famine. Many Haitians I have known or met, especially infants but also young people in their prime, are now dead. And medical interventions, regardless of scope, are merely palliative in the long term. They will not prevent diseases such as those that killed Marie-Ange, Acephie and Michelet; they do not help the victims of torture and starvation.

To again cite Father Aristide: "Haiti is the parish of the poor. In Haiti, it is not enough to heal wounds, for every day another wound opens up." But those who, like Aristide, have deplored the sinful structures that generate so much sickness and suffering have been, like Aristide, viciously persecuted.

I wish I could conclude on a happier note, but, as there still has been no reprieve for the poor of Haiti, I cannot. It is important to recall that the United States is the chief player in Caribbean politics, and our foreign policy here has not been honorable.

Noam Chomsky, in introducing a recent study of U.S. intervention in Central America and the Caribbean, put it as follows: "There is no way to give a precise measure of the scale of our responsibility in each particular case, but whether we conclude that our share is 90 percent, or 40 percent, or 2 percent, it is that factor that should primarily concern us, since it is that factor that we can directly influence."

It is not at all clear that we can, in fact, influence U.S. policy in Latin America, but citizens of good faith must continue to try. For the poor of Haiti, the stakes are life and death. ✻

Paul Farmer '90, instructor in social medicine at HMS, divides his time between the Brigham, where his research resides in internal medicine, and Haiti, where he continues to work with the same communities.

Righting Human Wrongs

by Terri L. Rutter



photo by Mike Levy, courtesy of PHR

Above:
Curtis Prout '41 examines a political prisoner in Port de Paix, Haiti during a PHR mission there in July 1990.

IT IS HORRIBLE TO CONTEMPLATE, and terrifying to think it could happen to you, yet untold numbers of people, some of them physicians, are tortured daily in areas around the world. A recent HMS continuing education course here, co-sponsored by the Department of Social Medicine and the Physicians for Human Rights (PHR), probed the issue of international human rights abuses and appealed to physicians to use their medical skills, combined with compassion and objectivity, to participate in the treatment of, and advocacy for, victims of such abuses.

Operating from the premise that physicians have a moral obligation to cure man-made epidemics with the same commitment applied to naturally occurring ones, the course provided instruction on the signs and symptoms left by torture, advice on how to treat torture victims, both medically and psychologically, and suggestions on how physicians can help to prevent torture, on a variety of levels. The course was directed by Carola Eisenberg, MD, HMS lecturer in psychiatry and head of International Programs for Medical Students. Eisenberg, one of the founders of PHR and a longtime advocate for human rights, was a member of delegations organized by PHR and sponsored by the American Health Association and the American College of Physicians that investigated reports of systematic violence targeted against health workers and their patients in El Salvador and Chile during the early '80s.

"We and the world desperately need you to stay involved," said Jonathan Fine, MD. Fine, who Eisenberg described as the "one who gave us all the moral courage to speak out," is the former chair of the national executive committee of PHR, and is now a consultant on human rights and medicine.

Robert Lawrence '64, one of the original founders of PHR and now director of the Division of Health Sciences at the Rockefeller Foundation, has conducted human rights missions to Chile, South Africa, Czechoslovakia, Egypt, and El Salvador, among other countries. The application of the basic skills learned in epidemiology, he said, is useful in recognizing patterns of torture. The victims of torture wear the evidence of it on their bodies: the small, round black scars from cigarette burns; long strips of raw skin and welts caused by whippings; and the tell-tale imprints from the torturer's shoe left on the victim's back.

These are the immediate results of torture, however. The long-term effects can be more evasive, but there are signs to be aware of. For example, victims of "Falanga," beating the soles

of the feet, often experience arthritis later in life, long after the physical signs of the torture have healed. Understanding and listening to a victim talk about the torture will also aid in treating the victim, said Lawrence.

Lawrence introduced Mohammed Mustapha Mandur, MD, who was tortured by Egyptian security forces during the Gulf war because he had treated Palestinians. Mandur recounted that even as he was blindfolded and led naked to his place of torture, until he actually felt the electric shocks, he could not believe it was happening to him. "As physicians, we are usually in a very powerful position, and we think torture will never happen to us," he said. This type of experience forever changes one of the most basic emotions—trust and faith in the human race, said Mandur.

"The physical sequellae of torture are very important, but the psychological sequellae are often most enduring," remarked Richard Mollica, MD, director of the Harvard Program in Refugee Trauma at the Harvard School of Public Health and clinical director of the Indochinese Psychiatry Clinic at St. Elizabeth's Hospital. For example, beatings to the head can lead to neuropsychiatric problems, such as memory deficits and confusion, which are nonresponsive to traditional treatments. Torture victims can also suffer from anxiety, depression, sleep disorders and social disability, and unless the torture and the culture in which the torture took place are understood, said Mollica, the patient cannot be treated appropriately.

The heart-rending tragedy of child victims of torture and of war were addressed by Jane Schaller '60, chief of pediatrics at the New England Medical Center and a professor at Tufts Medical School, and Elena Nightingale, MD, PHD, adjunct professor of pediatrics at Georgetown Medical School and special advisor to the president of the Carnegie Corporation. "It should not be acceptable to us to have a world where children are maltreated; it should not be tolerated," said Schaller.

In many countries physicians are called on to authorize that a patient is "fit" to receive torture.

Schaller, a pediatric rheumatologist who has visited a number of countries in Africa and Latin America on behalf of children, spoke of the tremendous damage to children caused by land mines. Globally, more children are harmed by land mines, she said, than by rheumatological problems.

Nightingale appealed directly to physicians to listen to children when they talk about their experiences, and to take them seriously. Children are frequently not believed when they talk about being tortured. For young girls, she said, rape is very common and leads to all sorts of later problems, both mental and physical. Her own advocacy efforts have focused on trying to involve the American College of Obstetrics and Gynecology on behalf of these girls.

Gathering accurate mortality data is essential to holding governments accountable for their actions said Paul Wise, MD, HMS assistant professor of pediatrics, who was a member of a data-collecting mission to Panama after the U.S. invasion there. Because societal and political disenfranchisement extends to the grave, said Wise, the struggle to produce an accurate count "is a form of empowerment, reporting mortality is a way of affirming life."

Many victims of torture apply for asylum in the United States. Nancy Arnison, director of the Refugees and Asylum Project of the Minnesota Lawyers International Human Rights Committee, discussed how physicians may assist this process. By corroborating victims' stories of abuse with the physical evidence—by testifying, for example, that scars or other sequellae are consistent with a particular form of torture—physicians can become involved here in the United States.

Physician compliance with and outright participation in torture was another much-discussed issue during the two-day course. Nightingale reminded participants that the euthanasia policies executed by Nazi physicians enabled the Holocaust to occur. It was the medical profession in Nazi Germany who invented methods of mass execution, she said, methods they first performed on children.

There are several ways physicians consent to and participate in torture. In many countries (including the United States regarding the execution of a death row inmate) physicians are called on to authorize that a prisoner is "fit" enough to receive torture. Physicians have been known to sign false death certificates, for example those stating that a prisoner died of natural causes. They may also participate in the torture itself, for example, psychiatrists who "treat" political dissidents imprisoned in mental asylums.

Discussants encouraged the audience to pressure international medical societies to expel physicians who have participated in torture. Encouraging international medical organizations, such as WHO to assume more active roles is another way to assure physician participation and compliance.

"Physicians have a natural obligation to uphold human rights," said Leon Eisenberg, Maude and Lillian Presley Professor of Social Medicine, in his lunchtime address, "The Physician as Double Agent." "If you don't start out fighting for human rights when you're a medical student, you won't do it when you're a graduate physician or a full professor. You'll wait all your life for the moment and never find it." ✻

Terri L. Rutter is assistant editor for the Harvard Medical Alumni Bulletin.

A World of Wonders

Photographs by Rosamond Purcell

THE *BULLETIN* IS PRIVILEGED TO HAVE a gallery of Rosamond Purcell's illuminations. The existential qualities of her photographs speak for themselves through her imaginative arrangements and use of natural light. Since some readers may find the subjects disturbing, a few words of explanation are called for.

In the July/August 1987 issue of *Harvard Magazine*, Purcell and William I. Bennett '68 collaborated in a photographic exploration of Harvard's Warren Museum. That museum, which many of us remember occupying the top three floors of Building A, is largely a thing of the past, forced to the wall on the fifth floor and to storage by pressure of administrative and teaching *Lebensraum*. Purcell's photographs and Bennett's amusing (when you consider the nature of the subject) chronicle are its enduring memorial.

The present selection of Purcell focuses attention on another anatomical museum, still thriving at the University of Leiden in the Netherlands, and, among others, on the distinguished work of three of its late 17th-, early 18th-century anatomists: Frederick Ruysch, Jacobus Rau and Bernard Albinus.

These three flourished a century after Vesalius and Harvey, and long after Leeuwenhoek introduced microscopy into the Low Countries. Boerhaave, an eponym popular in oral exams, was their contemporary, in fact, dean of their school. They lived in an age when death was a familiar and ever-present reality, not shut away or sequestered in hospitals, nor exploited in the inane violence of our present "entertainment" world. Death was very much a presence in the Calvinist Low Countries, where life was rather haughtily regarded as *vanitas mundi*.

In this context even Ruysch's Third Thesaurus (he used the term to mean treasure), shown on the next page becomes acceptable, even a friendly gesture. Purcell seems to have caught the spirit in her juxtaposition of two 19th-century skeletons, one gracefully bowing to the other. Death is personalized, while at the same time the pathological anatomy of kypho-scoliosis is displayed.

Ruysch (1638-1730) was a master of injection techniques that marvelously preserved the life-like qualities of tissue. The face of an infant is an example. And note the quaint decorative use of lace—a feature carried to an extreme by his pupil Albinus in the tasteful display of an arm daintily holding an eyeball, a photograph that inspired the delightful essay by F. Gonzalez-Crussi, entitled "Anatomy and Old Lace" in *Sciences*, the Bulletin of the New York Academy of Sciences, Jan./Feb. 1988.

Along with superb anatomic preparations, Ruysch produced 10 thesauri similar to the Third noted above, which bore cheerful sloca such as "Man's life is but a game," in Latin, of course. All his thesauri and virtually all his museum or cabinet of anatomic preparations were much admired by Peter the Great, who "collected" them in 1717 to grace his *Kunstkammer*, or chamber of curiosities.

It is not surprising that these elaborate, whimsically macabre but dust-catching thesauri did not survive the housekeeping instincts of Peter's granddaughter-in-law, Catherine. They were discarded and their components scattered. The hope that their remains might still be found helped inspire Purcell's *glasnost* visit to the Leningrad Museum two years ago in search of Ruyschiana. And this, in turn, became a chapter in a study of collectors, *Finders Keepers: Eight Collectors*, photographs by Rosamond Purcell, text by Stephen Jay Gould (W.W. Norton, September 1992).

As Gould points out, if ever the soubriquet "the Great" was rightly applied to a ruler, Peter the Great would qualify. At 6 feet 7 inches, he was a towering figure in all respects. His *Kunstkammer* was indeed a Chamber of Wonders, even such global trivia as the collection of teeth that he, as one of his hobbies, extracted and identified, sometimes without informed consent.

Rosamond Purcell gives us a glimpse of a world of wonders—something akin to Alice's glimpse of the garden beyond the very small door that required shrinking before she entered. We enter that world through Purcell's "illuminations."

J. Gordon Scannell '40



Above:
These early 19th-century figures come from an extensive collection of pathological skeletons, now at the University of Leiden, the Netherlands. Photo 1987.



Left:
Engraving of the third thesaurus from Thesaurus Anatomicus Tertius (Amsterdam 1744) by Frederik Ruysch (1638 – 1731). Ruysch used the term thesaurus to mean treasure.





Left:
Prepared by Bernard Albinus (1697 – 1770) in the mid-18th century. The arm, preserved with a mixture of wax, dye and cinnabar, delicately holds an eye socket between its fingers. Photo 1986.

Above:
Fetus with dye-injected lining of uterus suspended in a jar by the thorns of acacia tree. Prepared by Johannes Rau (1668 – 1719); University of Leiden, the Netherlands. Photo 1989.

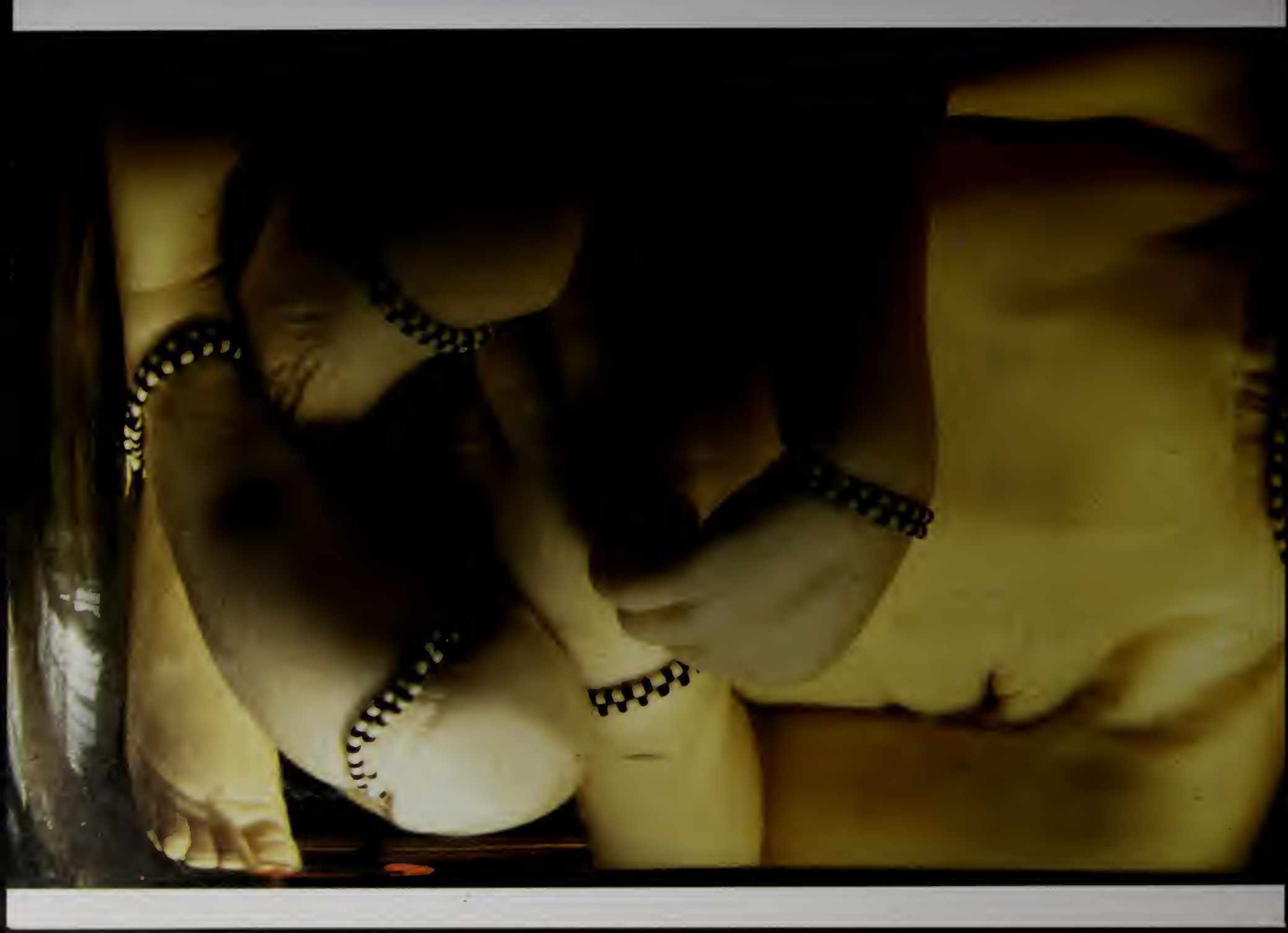


Above:
Teeth pulled by Peter the Great, mid 1700s. Individual teeth include one from Peter's nurse, one from a court lady, and one "from a fast-running messenger." Photo 1990.

Right:
Baby with lace collar, from the collection of Ruysch, 1717, purchased by Peter the Great, St. Petersburg. Lace is often seen in specimens prepared by Ruysch, and was decorated by his wife and daughter Rachel, who went on to become a well known painter. Photo 1990.



Opposite:
Found in St Petersburg in the collection of Peter the Great, this "beaded baby" could have come from Ruysch. Similar babies were brought by sailors to Holland, possibly as early as the 1700s, and possibly from Africa. The purpose of the decoration is unknown. Photo 1989.



Soviet Medicine Before and After the Fall

by Mark G. Field

THE FALL OF THE COMMUNIST system and the collapse of the Soviet Union is one of those unprecedented and largely unpredictable events that will change the course of history. Whether that collapse was the result of endogenous or exogenous factors, or more probably a combination of both, remains the subject of endless speculations.

It is quite likely that certain structural weaknesses of the Soviet system were exacerbated by the Cold War. Many years ago, someone suggested that the West should spend the Soviet Union into bankruptcy, meaning that the Soviet system could not afford to match the West in military expenditures and, in its attempt to maintain parity, would ruin itself.

Whatever the reasons, the fact is that the Commonwealth of Sovereign States is in dire straits at the present, particularly economically. The consequences of the transformation of the Evil Empire into an international beggar is bound to have repercussions, not the least of which is the further deterioration of the population's health and the transformation of Soviet socialized medicine into a very different health care system.

For many years, the Soviet Union boasted of its system of medical care, holding it up as a model for other nations to emulate. It constitutionally guaranteed universal, free and qualified medical attention. It was often depicted by its advocates in the West as one of Soviet society's most important redeeming features. Yes, people would argue, the Communist system is not a democracy, *but* it pioneered socialized medicine. The *but* reminds one of the argument that Mussolini was a dreadful tyrant *but* he made the trains run on time (which apparently he did not).

By the same token, the reality of the Soviet system of medical care, particularly in the past 30 years, has been quite different from the propaganda.

If the British Navy can call itself, and with justification, the senior service, the Soviet health care system before the "fall" would not even have qualified for junior status. Rather, it should have been known as the "residual service." Residual in that, as former Health Minister Chazov complained, the financing of that service came last, after all expenditures had been met, and it had to take whatever was left, which was very little.

The very low priority accorded medicine (with a major exception, as we shall see later) reflected the fact that in the Soviet scheme of things, medical care did not produce quantifiable industrial, agricultural or military goods, such as machine tools, wheat, automobiles or tanks. And, although it would be possible to justify investments in health as economically sound, and indeed profitable, the argument apparently did not carry the day in higher party and government centers. The health care system cost money, period.

Health personnel, as a result, consistently received the lowest incomes of all occupational categories, approximately 70 to 75 percent of the national average. Some efforts were made in the mid-80s to raise salaries for both the physicians and the woefully underpaid nurses, but these were only token raises.

Perhaps equally symptomatic of the financial starvation of the service—indeed a neglect that some might term flagrant—was the fact that starting in the mid-60s, the proportion of the gross national product earmarked for health fell, whereas in practically every industrial nation it rose, indeed reaching crisis proportions in the United States. The United States spends about 12 percent of its national wealth on health, and the West European countries and Canada about 7 to 9+ percent. And that figure is rising everywhere.

In 1965, the share of the Soviet GNP devoted to health was about 6.6 percent; it fell to 4.1 percent in 1970, and to 3 percent in 1980. Between 1985 and 1989, it hovered between less than 3 percent at first, then rose to an estimated 3.4 percent in 1989. It is probably lower than 3 percent now. These figures may be slight underestimates because of formally illegal "under the table" payments, which I will discuss later. In 1988, Health Minister Chazov stated that, on an international scale, the Soviet allocation of the GNP to health ranked about 75th out of 126 countries.

If, in addition, we can estimate that in those years the Soviet GNP was somewhere around one-half that of the United States, we can see the rather large disproportion in this area. While health expenditures are now said to be out of control in the United States, in the Soviet Union they were over-controlled, a situation explained in part by the fact that practically all health expenditures were financed by and through the public sector. The government was thus in the position to effectively turn the faucet on and off. This is a situation that cannot be compared to that of the United States, where a large proportion of such expenditures are channeled through the private sector.

But the unavailability of funds in the USSR was not the only problem. In many instances there was nothing to buy: no medical equipment, bricks and mortar to repair hospitals, pharmaceuticals, and so on. Thus, budget lines were often as useful to hospital directors and clinicians as hundred dollar bills to someone stranded in the Sahara Desert or Antarctica. Only a small proportion of hospitals (particularly in the countryside) had been built originally as medical facilities. It was also not unusual for hospitals, particularly in Central Asia, to be without sanitary facilities. Again according to Chazov, only 35 percent of rural district hospitals had hot running water, 17 percent had no running water at all and 27 percent had no sewerage.

Patients, in most instances, paid considerable sums of money "under the table" for the care they were supposed to receive free of charge.

The one major exception to this bleak picture was the so-called "closed facilities" reserved for the elites and other more privileged members of Soviet society. It is a general rule, and a universal one at that, that medical care follows the stratification pattern of the social system, and that everywhere, East and West, the elites know how to take care of themselves.

As Vladimir Mikhailovich Lupandin remarked in *Meditsinskaia Gazeta*: "There developed two pharmacopoeias, one with aspirins and mustard plasters, and the other with the very latest foreign pharmaceuticals, including antibiotics. Some regional party committees already had their own water supply, fed from artesian wells, and separate from the polluted water from the river," destined for ordinary mortals.

But since, as far as we know, the closed medical facilities were funded primarily by the Health Ministry, and since they were better equipped and had more personnel than those reserved for the rest of the population, the latter had to make do with but a fraction of already meager resources. And, of course, those who did enjoy the use of the special or elite facilities were but a small proportion of the total population. Christopher Davis estimated in 1979 that 1/10 of 1 percent of the population (or about 200,000 persons) had access to elite facilities. If we add to that percentage those served by departmental health services (facilities reserved for members of different bureaucracies, the armed forces and the secret police), we can add another 5 percent, or about 12,700,000 persons. But the other 95 percent had to content themselves with inferior, overcrowded and understaffed facilities.

In Moscow, in 1987, about half of all doctors worked in special or closed polyclinics and hospitals. No wonder then—in a system that claimed it had more doctors per capita than any other country in the world—people had to wait hours, sometimes days, to see an overworked physician, who usually had five to seven minutes per patient, half of that time spent on paper work. Furthermore, those who enjoyed elite facilities and their amenities did so as a perquisite of rank for which they made no payment. (In the United States, we would call this welfare for the rich.)

But this is not all. Of that small proportion of the GNP allocated for health care, one caveat is in order: given the nature of shortages characteristic of the Soviet system, and the poor official pay of personnel, corruption in most, or all, sectors was (and probably still is) endemic. Patients, in most instances, paid considerable sums of money "under the table" for the care they were supposed to receive free of charge: surgical interventions, deliveries, clean sheets, medications and so on. Free medical care had become a sick joke.

It would be impossible to estimate or aggregate these "underground" payments, though they were reported to average from the equivalent of a month's salary of a regular doctor to often more than two and one-half. But they undoubtedly lifted the proportion of the GNP devoted to health, though again, the amounts must be left to conjecture. A survey of the population some time ago disclosed that three-quarters of those polled said they had given money to health personnel, presumably to secure better, more personalized attention or as a token of appreciation or both. But what is significant is that these payments were made by, or extorted from, the ordinary people, i.e., those least able to pay.

The Noble Purpose

The history of Soviet socialized medicine may be divided into roughly two phases. The first, from the revolution to the end of the 1920s, was dominated by the ideas of social hygienists and true-blue Marxists, whose views were that illness and premature mortality were the product of a "sick" social system (i.e., capitalism), and that the advent of socialism, and eventually communism, would usher in a new period in human history, one that would be increasingly free of the socially produced ills and evils of the former system. The social hygienists also held that the etiology of sickness and early death was to be found in the social habits and institutions, and should be addressed not primarily through remedial medical care, but in the reformation and transformation of society, and the education of the population.

This then led to a preventative and sociological orientation of medical schools and the formation of the Commissariat of Health Protection (founded by a decree Lenin signed in July of 1918). The "pathologies" they were concerned with were therefore more social than biological: alcoholism, drug addiction, prostitution, industrial hygiene and so on.

This approach, which fitted well with Marxist theory, constituted at the same time a powerful critique of society and was thus, in essence, political. It was well and good when it applied to capitalism and the early post-capitalist period with its heavy legacy of a contaminated past. But it did not sit well at all with the Stalin regime once the decisions to industrialize under forced draft and to collectivize agriculture had been made. Since the strictures of the social hygienists applied equally well to conditions in Soviet society, which indeed were exacerbated by Stalin's ruthless programs, they simply could not be tolerated. Thus the emphasis turned 180 degrees, and the health care system was reoriented toward the classical clinical approach.

The emphasis was moreover utilitarian, or functional: medical care was not so much aimed at reducing pain and making life easier and longer, but at maintaining and repairing the working capacity of the people. Of course, in its manifest or explicit presentation, the provision of medical care at the expense of the state was depicted as one more achievement of the regime and its dedication to the well-being and the welfare of the people.

This was embodied in that provision of the constitution that promised free health care to all. This universal entitlement, regardless of ability to pay or any other qualifications, has since become standard in most industrialized societies under one type of arrangement or another (health insurance, national health service, and so on) with the exception of the United States and South Africa. It answers a universal yearning for health security from birth to death, or as some would have it, from the womb to the tomb.

In 1936, the creation of the All-Union Commissariat (later Ministry) of Health Protection reflected the Soviet commitment to centralization, standardization and control at the national level, and placed practically all medical care and public health under the aegis of the party and the state. The health minister became a member of the cabinet, responsible for the health care of the nation. Soviet socialized medicine thus became a huge bureaucratic structure, employing several million people and financed almost entirely from the state budget.

Physicians became state employees or bureaucrats, without any corporate power as a profession (for example, an independent association of physicians that could represent or defend their interests before the state). The fact that they were paid by the state (and indeed had been trained at state expense) also made it possible to keep their official incomes or salaries at a relatively low level. A former Soviet doctor once recounted that when he worked at a large industrial plant, some of the engineers made fun of the physicians because they were so poorly paid. He had a quick retort: "You see, in our country, you get paid according to the value of the materials you work with. You engineers work with equipment purchased abroad with gold. We doctors only work with poor slobs like you whose worth, obviously, is reflected in our pay."

But one might also wonder at the rationale, besides saving money, of course, of paying medical personnel so poorly. I have already suggested one factor: that medicine is not "productive" in the industrial sense. One would thus pay engineers more than doctors or teachers. But also the nature of the work itself led to a decision, made quite early, that medical care, like elementary school teaching, could just as well be woman's work, and woman's work is usually paid less than man's. The large proportion of women in medicine (close to 70 percent at the present) may be cause and effect.

An effort was made to increase the representation of men in medicine, but the results so far have been negligible. At the same time it should be noted that the higher levels of the medical hierarchy in the ministries, the research institutions, and in the Academy of the Medical Sciences were overwhelmingly staffed by men, who

drew higher commensurate salaries.

Next, given the corrupt nature of the health care system, and the age-old custom of giving additional monies or gifts to health personnel, perhaps the regime reasoned that the poor official incomes would be more than made up for by "payments under the table." This is sometimes called "envelope-passing" medicine, as patients hand the cash in a more dignified and more discreet manner, since such payments are formally illegal.

This does not sound unreasonable in light of the fact that the average salary of a physician was in the vicinity of 200 rubles per month. Before the fall of the Soviet regime, a regular physician received a monthly income lower than that of a qualified worker. Here are some excerpts from P. Makeyenko and L. Manukyan, two correspondents from Izvestia who visited Baku in 1987. This was probably typical of the general situation then.

An operation here in Baku costs the patients' relatives roughly 500 rubles now...no one at the hospital comes right out and demands money but...you understand no one will come near you, and the necessary medicine or whatever won't be found...And this happens not only in the hospitals—in the maternity home no one will look at a woman until she has paid...A baby costs a lot of money now, the relatives have to have 500 rubles.

Finally, trying to understand the neglect of health care by the authorities, we cannot dismiss the factor of stratification mentioned earlier: the pampered bureaucracy, the partocracy, were well taken care of medically (and otherwise)—the *nomenklatura* saw to it. For the rest of the population, they displayed the insouciance, the Marie Antoinette complex, of an indifferent upper class or aristocracy.

And it may very well be that an important component in the hatred of the Communist regime by the population was the fact that high quality medical care was accessible only to a few privileged members of society. People may well accept the legitimacy

Medical care was not so much aimed at reducing pain but at maintaining and repairing the working capacity of the people.

of higher incomes and many perquisites of rank (including housing) that go with different occupational and political responsibilities. But health care involves more than money and dachas. It touches on issues that are emotionally charged: life itself, pain or incapacitation. To know that in the "closed" clinics and hospitals there are antibiotics and other medicines that could save the life of a dear one, one's child or oneself, and to realize these are inaccessible because one is not part of the mighty is, I surmise, a powerful source of antagonism and resentment.

In the last few decades, during the Brezhnev years, and exacerbated by the economic slide that accompanied Gorbachev's *perestroika*, the system of socialized medicine simply deteriorated, suffered from neglect, and was (and still is) plagued by shortages of capital, equipment, maintenance, pharmaceuticals, and especially antibiotics—in short, all the elements, except personnel, that constitute a state-of-the-art medical care system. And even those personnel, if we are to believe former Minister Chazov, were in many instances poorly trained and often unqualified to perform the simplest medical tasks. The dissolution of Soviet society was thus paralleled by the gradual disintegration of its system of medical care, making a mockery of the promises embodied in the constitution.

At any rate, the parallel deterioration of the economy and the health system led to a worsening of health indicators including mortality, particularly infant mortality, which is in fact a proxy measure that reflects socioeconomic conditions and is very sensitive to changes in these conditions. After the early 1970s, infant mortality began to climb, and in the last 20 years or so has remained at an officially reported national level about two and one-half times greater than that of the United States. And it would be fair to estimate that in the Central Asian republics, particularly in the countryside, it was likely to be two to four times the national figure.

There is also evidence that, in many instances, infant mortality data were fudged or faked to make them look better. Thus if an infant died at 11 months, it would be reported as one year, one month, thus taking it out of the infant mortality rubric. Chazov noted with his usual frankness in 1988, "We took pride in our system of health care....But we kept quiet about the fact that in infant mortality we ranked 50th in the world after Mauritius and Barbados."

By the same token, the overall mortality rate in the Soviet Union in 1988 was 40 percent higher than in the United States: 50 percent for males, 40 percent for females. When disaggregated by selected causes for males and females, the Soviet index was higher in all instances except for female neoplasms (cancers) and female motor accidents (10 percent less in the USSR). It was equal in only one category: female deaths from digestive diseases. Writing a few years ago, a French demographer commented: "One has never seen, in peace time, a regression of health conditions (as measured by mortality) of such magnitude."

To summarize then, the health care system suffered, and probably does so even more today, from a lack of resources, a suffocating bureaucracy and hierarchic structure, an unequal distribution of resources, and from neglect and corruption. Indeed, the

dislocations, the shortages, the disorganization, and the rampant inflation of the last few months can only exacerbate the problems of medical care, and in tandem with the breakdown of the system in general, place the welfare and the health of the population in double jeopardy.

Proposals to provide emergency assistance to the former Soviet Union usually bracket, and for good reasons, "food and medicines." Indeed food is more important than medicines, but medicines come a close second. The solution to the medical problems left by the failures of the Soviet regime will come only with the solution to the economic, social and political problems left from the past. What then are the likely prospects in the near future in this domain?

The Legacy

A historian is reputed to have said: "Don't ask me to predict the future; but when it happens, I will be glad to explain why it was inevitable." To forecast the future trends in health, health care and vital statistics would be foolhardy. And yet, the legacy of the Soviet era is clearly visible and will shape to a large extent the evolution of the situation.

At a more general level, I expect that the collapse of the Soviet system will bring along further political instability and economic hardships. In fact, at the present time, the economy is in a free fall as a result of a precipitous fall in productivity and production, brought about by the lack of institutionalized wholesale and retail markets and exchange mechanisms. The command system in the economy has disappeared, which, as inefficient as it was, had at least the virtue of ordering the movement of goods and commodities to those who needed them.

These trends are likely to increase the risks to the population, including shortages of food, and by continued deterioration of the environment through uncontrolled pollution of air, water and soil. Women of child-bearing age, nursing mothers, children, the elderly and the poor will be most affected. Not enough vaccines will be produced or procured. In addition, as Murray Feshbach has reported, many children are already suffering from vitamin deficiency and the effects of environmental problems.

Recent reports from economists in the Russian Republic indicate that "pregnant women appear to be in poorer health than a year or two ago, and malnutrition is more common." This is not surprising in view of the current estimates that about 90 percent of the Moscow population (and presumably other large urban centers) live under the poverty line.

The outbreak of epidemics is a distinct possibility, and the toll they will take in morbidity and mortality will be in direct proportion to economic dislocations and shortages of all kinds. It is then to be expected that a deteriorating social, political and particularly economic situation will have devastating effects on the health of the population, which was not in great shape even before the events of August 1991.

The health care system, weak and poorly supplied to begin with, will further deteriorate, particularly as clinical facilities face increasing shortages of all kinds: financial resources, equipment, pharmaceuticals, fuel, food and other items that are scarce. Hospitals, particularly those in the Central Asian republics and in the countryside in general, will increasingly resemble those of a Third World country, and will, to a large extent, depend on assistance from the West.

In 1989, one-quarter of the children who should have been vaccinated against polio were not; one-fifth were not immunized against diphtheria; and one-third against whooping cough. If this was the situation before the collapse of the Soviet Union, one can well imagine how far worse the situation is likely to be afterward.

As the bureaucratic medical system established by the Soviets gradually collapses, it is likely that an increasing number of physicians will attempt to set up individual and private group practices. But most will not be able to do so given the economic deterioration. They will continue to depend on whatever health bureaucracy remains, and their purchasing power is likely to diminish as time goes by.

The *Meditsinskaia Gazeta* (Moscow) reported in February 1992 that physicians were going on strike. One of the placards carried by the strikers said: "A hungry surgeon is dangerous to your health." Another one included a variation on this theme: "Free medical care is dangerous to your health!" The *Gazeta* commented: "In what ways are doctors different from miners?"—an occupational group known for its propensity to strike.

As physicians are liberated from their status as state functionaries and employees, independent associations of physicians may be formed to represent them and to defend their interests in an increasingly pluralistic and hopefully democratic environment. Some of them will undoubtedly publish their own journals. We may thus see a trend toward the re-professionalization or the de-proletarianization of the medical corps in the direction of self-governing corporate bodies.

This will, of course, take time and money, but could increasingly raise the status of the medical profession to par with their colleagues in the West. It is interesting to note that in the West, physicians are concerned about becoming bureaucrats and employees, and losing their independence and clinical autonomy as attempts are made to decrease medical costs. Thus, cautious visions of "convergence" from different starting points may well appear on the horizon.

Soviet medicine had consistently rejected both the idea of private practice (with its connotation of the physician as a businessman) and the concept of charity, which had no place in the Soviet scheme. With the re-birth of private practice and private initiative, we may well see an increase in charitable and volunteer activities providing care for the very poor and assisting in hospitals. Usually inspired and orga-

nized by the Church, these charitable activities serve in the dual capacity of helping and of giving spiritual, emotional or psycho-therapeutic aid.

The population will continue, at least for the foreseeable future, to expect that medical care is a right of citizenship, and that the individual unable to pay for his care should not be deprived of needed services. The idea of universal, though not necessarily equal, entitlement will probably remain. But the manner in which this provision will be implemented will remain an open question for a long time given the failure of state socialized medicine, Soviet style. This then may facilitate the establishment and the acceptance of a variety of schemes, especially health insurance, which will provide coverage for certain designated groups (industrial workers, white-collar employees) supplemented by some kind of state-sponsored arrangements for those not covered (unemployed, housewives, students, the retired).

At the same time, we may well expect the continued existence of stratification and inequalities in the delivery of health services, probably a two-tier arrangement, though the composition of the population in these two (or more) tiers will change. The affluent, the well-connected and the powerful will, undoubtedly, be able to purchase or otherwise obtain better medical care in better equipped facilities, ones with more amenities, than the poorer members of the population. In any stratified society, the provision of medical care follows that stratification, and there is no reason to assume that the post-Communist world will be different.

We also may expect changes in the structure of the medical research establishment, particularly the institutions under the control of the Academy of Medical Sciences. Although it can be assumed that the academy was relatively free of party dictation, in fact it was not. Lupandin, in a recent article in the *Meditsinskaia Gazeta*, has pointed to the fact that

One placard caried by a striker said, "A hungry surgeon is dangerous to your health."

three academicians had been closely associated with the punitive use of psychiatry.

But these changes will take place slowly and unevenly. I would venture that in the course of the years to come, the health system of the republics will increasingly begin to resemble some of those that have emerged in the post-World War II period, particularly in Western Europe. These systems all seem to embody some kind of mix between private and public initiative and financing; a commitment to universal coverage at no cost at the time of service, or with cost-sharing; some kind of explicit rationing process in light of the ever-expanding demand for services (fuelled both by demographic changes and by an expensive technology that is both labor and capital intensive), and the need to contain exponentially rising expenditures.

It is thus possible that both the pluralistic system of the United States and the socialized medicine that existed in the Soviet Union may meld into some kind of amalgam of insurance medicine and state financing of the type seen in most industrial states. But both the nature of the health problems in the former USSR and of the health system will depend on the evolution of the societies emerging from the ruins of the Soviet Empire, and in their economic progress. In health care the process is going to be long and tortuous, and every solution or reform adopted will eliminate some glaring problems of the past and generate new ones for the future. This is indeed a universal phenomenon.

Looking at the United States and its plethora of health issues, the former Surgeon General C. Everett Koop said of health reform: "If we were all men of good will, which we are not, and if we could agree on how it should be done, which we can't, and if we had the money, which we don't, it would still take 10 years." The same could be said of the situation in the former Soviet Union, but the time dimension is more hypothetical. ✠

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Imor

by Mohammad Bahman Beigi
translated by Farrokh Saidi

One day back in 1955 or '56 Edward D. Churchill '20 stopped me in Mass. General's White Building to ask if I knew anything about the Ghashghais. He had just come back from a trip to their part of the world. I answered truthfully: "Nothing except that they are nomadic tribes in south Iran." Five years later I came to know those tribes pretty well, especially a very well-educated tribesman, Mohammad Bahman Beigi, who had become a legend in his own time during the years I worked at Pahlavi University in Shiraz. Single-handedly he had organized a very efficient tribal school system, and just before the Revolution broke out, he had a half-million youngsters in tent schools.

Queen Fabiola of Belgium, as part of a long retinue of visiting dignitaries, wanted to see nothing but this man at work, much to the consternation of the Shah, who did not like being outshined by others. The ex-Soviet Union, South American and Australian governments, among others, were all on the waiting list to have this man tell them what to do about their tribes!

All that came to a halt with the Revolution. During the first few post-revolutionary years, when Bahman Beigi, like so many other former government officials, was hunted and haunted, I urged him to put down on paper his experiences, recording for posterity the highlights of a bygone era. This he did.

The result is a remarkable book of short stories in Farsi. It has delighted local readers while opening a back window upon a colorful place and a people who are rapidly receding into history.

For reasons I cannot explain, I felt the urge one day to try my hand at translating some of his stories. I enjoyed it. And what came out rather effortlessly seemed to some local friends to be a quite good and true expression of the original. The following is one of those stories.

Farrokh Saidi '54

AT THE BEGINNING OF THE 20TH CENTURY, AND TOWARDS the end of the reign the Ghajar Dynasty, the Ghashghai tribe of Southern Iran had become more powerful. The whole of the vast area between the Persian Gulf and Isfahan had become the domain of these nomads, the roaming ground of its horsemen. Clans, subtribes and subsubtribes of the Ghashghais, with thousands upon thousands of armed and fearless men, had taken over law and land, bringing people under their will and rule, to create a state within a state.

These tent-living, Turkish-speaking nomads had a mobile capital of their own: this seat of the government would settle in wintertime in a plain within the mountains, a natural enclosure called "Kazem's Well" near the ancient Sassanian palace at Firoozabad, southwest of Shiraz. And it would move north in summertime to another hospitable plain, "Nokhodan" at Semirom, below Isfahan.

The seat of its government, the royal palace, was a huge black tent that was invariably pitched in the midst of other tents occupied by the large family of the reigning Ilkhan. Some were living quarters, some guesthouses, and some were schools for the beloved children of the ruling families. Other tents were occupied by scribes and some housed tribal archives. Some were kitchens, others were quarters of the guards. There were tents that served as prisons, and there were tents that stored fearsome weapons of every type and make.

In the Ilkhan's prison, as in prisons everywhere around the world, common criminals and political prisoners were kept separately in chains fastened around their wrists and ankles. Once in a while a famous prisoner would be dragged in front of the big Khan to be flogged in public. Fear would run down everyone's spine and terror would strike into the heart of all the big Khan's subjects. And when Fazlollah, the grand canoneer with the bushy long moustache, took position behind his canon and picked the crest of a nearby hill to shoot at with one of the Khan's fieldguns, dread would descend upon the whole tribe.

The big Khan's stable boasted some of the most beautiful, most agile and most thoroughbred horses of the tribe. Among all the subjects of the Khan—men, women, children and beasts—only the horses carried identity cards. Their ancestry, parentage, age and other data were clearly recorded.

No one within the large moving community could read or write, no one that is except the handful of scribes and a teacher from Shiraz and his few pupils. Medical and dental care for everyone in the capital was entrusted to some experienced old women, a few barbers and a number of soothsayers. When either teeth or babies were to come out, wailing of the lord of the particular tent, servants, and even sometimes the Khan himself, would rise to heaven above.

IN HEAVENLY SPRINGTIME, WHEN flowers on earth were more numerous than stars in the sky, and primroses and camomiles would augur a bountiful year, the tribe and its capital would start to move towards summer quarters. Men and women, old and young, sick and well, horsemen and foot travelers, brides and bereaved, canoneer, teacher, scribes, henchmen, convicts, all and all would rise and move on. A colossal, colorful caravan many miles long would be off on its seasonal migration.

Some, with necklaces of pearls, would travel alongside rows of prisoners bound together by iron chains fastened around their necks.

It is always possible for settled city-dwellers to hide wealth and poverty, sickness and well-being, even from neighbors. In a tribal setting without walls or fences, especially so at times of migration, all differences among households would be laid bare. The rich horseman astride his gilded saddle would stride alongside a decrepit donkeyrider swaying upon his threadbare pillion. The wealthy tribal lady clad in silken veil on a sturdy mule moved along a walking mother with a babe fastened to her back and another trodding beside her. Some, with necklaces of pearls, would travel alongside rows of prisoners bound together by iron chains fastened around their necks.

The migratory path was long and winding. Dense forests, treacherous passes, steep mountains and wide streams had to be negotiated. For the rich and healthy the journey was a delightful adventure, for the poor and debilitated an ordeal.

The tribe was on the move. No one could fall behind. The weak and the strong had to move on. Those who could move, moved and anyone who could not was left behind. Neither death nor birth would halt the tribe. Nothing but the will of the Ilkhan himself could stop the migration.

In an open plain some 40 miles north of Shiraz, called Beiza, a beloved, trusted and respected minister to the Khan fell ill. This was enough reason for the Khan to order a halt to the migration. Assadollahkhan, who carried the title of Viceroy, had come down with a terrible eye disease. The Khan himself loved him more than his own eyeballs as he depended on this trusted minister's vision. Their companionship was so binding that Khan's family members dared not go against Assadollahkhan, who lacked nothing in courage and bearing. The sound of jubilation and roar of admiration rose when the Viceroy, clad in his long woolen robe, wearing his hat askew, atop his galloping horse, would bring down one wild deer after another.

Now evil eye had taken hold of the Viceroy, who could no longer see, ride or shoot. Experienced old women, skillful barbers and wise soothsayers could do nothing. And so the tribe was standing still.

A number of prominent physicians from nearby Shiraz were invited, but there was no eye doctor among them. Thus it was decided that Assadollahkhan should be taken to Tehran.

This was difficult. The iron horse on rails had not come to Shiraz. Only two or three ranking persons in the whole province owned an automobile, the Ilkhan himself being one of them. In a profound gesture of magnanimity, the tribal leader's personal motor vehicle was now placed in the service of the Viceroy.

An equally difficult task was to find a suitable companion-servant to attend such a prominent traveler-patient on his arduous journey to bustling and bizarre Tehran, 600 miles away. Many volunteers vied to show their loyalty and devotion in the service of their master. The one finally chosen, on merit alone, was a bright young man named Imor.

MANY YEARS AGO, DURING A TERRIBLE DROUGHT, IMOR HAD lost both parents, and the Viceroy had taken the orphan into his household. In no time at all the little boy had shown his exceptional intelligence and capacity. He advanced rapidly from a mere domestic appendage to the rank of the master's servant. For other servants he was not a rival but a sore. Single-handedly he cared for one and all.

Imor never walked, he flew. He never put a foot in a stirrup, but slid up always on the horse's saddle. Sleep or wakefulness was at his own command. As a night sentry, no creature, still or moving, dared approach the tents.

As a hunter, Imor was more a sorcerer than a game-chas-

er. He would tell each bird by the mere looks of its footprints. His gaze penetrated the darkness of night. He would separate the male and female of all animals from any distance. His shot would never fail, and most birds he would bring down in flight with the simple throw of a stone.

Nothing was beyond Imor's ken. He would shear a sheep without leaving the slightest scratch on the animal's skin. He would nail a horse's hoof as if the beast had been born nailed. And the most rebellious young stallion would be tamed in no time. The scythe would be a mere surgeon's knife in his hand at harvest time. At weddings he would jump to the dance ahead of everyone, his agile body twisting as a spring. And yet he could hold up a tent in any hurricane as steady as the sturdiest pole. In crossing rivers and stream he would ferry across the old and the young faster than the current.

Imor had a clear head, a strong memory and a matchless intelligence. He spoke Farsi, Turkish and Lury. No lack of parents and no amount of poverty could cover up his inborn rich talent. Imor was a fireball.

Viceroy and Imor reached Tehran and settled in a house that belonged to a wealthy past Ilkhan of the Ghashghai tribe. Following a lengthy period of medical examinations, treatment began.

Imor was stupefied by the glimmer and glitter of the capital city, its paved streets, tall buildings, spacious squares and bustling bazaar. Neither his dreams nor his imagination had prepared him for what he now saw. It was totally beyond the grasp of someone who had seen nothing more of settled civilization than small villages of the Fars Province. Longing for the wide open spaces he used to roam about, and soft desert sand he used to tread upon, he felt caught in the maze of alleys and winding kouches, seeing thousands of shepherds and hunters chasing him.

Their first few days in Tehran proved especially hard on Imor. Everything and everywhere was strange and foreboding. He could not lift his gaze from places and people, their clothing and behavior. The shining cobblestone pavement of the famous Lalezar Avenue, the powerful surging up and cresting down of fountain water in Parliament Square, the rows of shops with huge glass windows in front of all those goods, the multi-mirrored shopping plazas, all those colorful lights, the one- and two-horse droshkies and the milling bicycles caught and held his eyes. Imor had never looked so much and so hard in his life. And he could not stop looking. Or asking. But his questions went mostly unanswered. He spoke Farsi, but his dialect was strange—a mixture of peasant and tribal colloquialism.

Imor's clothing and mannerisms were equally odd to Tehranis. He looked as if that famous Lotfalikhan of the previous Zand Dynasty—with those big dark eyes, and bushy eyebrows meeting in the middle above the nose, and that colorful long robe reaching down to his knees—had walked straight out of his portrait frame.

Imor was filled more than he could hold with things to be seen and taken in. Yet he felt empty, above all empty for company. He yearned to talk, and to listen, especially of things and people. But for him there was no speaking tongue and no hearing ear in all of noisy Tehran. There were no Ghashghais in this crowded capital besides the Viceroy, and that man was too ill to talk except to order others around.

Imor had never once in his life slept in a room, and now he could not fall asleep in the closed space of a room. His heart felt tight and his breath blocked in his lungs. He felt terrified of enclosures, hating all walls. Evil walls separated men from each other. No one was anyone else's neighbor anymore, never seeing each other through walls. Men could not gather at dusk around the dancing flames of fire to talk to each other.

His thoughts about the tribe would not leave him for a moment. He yearned to go back. He was sorry he had come. He was anxious to escape this prison! But how could he return? How could he leave the Viceroy? What would he tell the tribe and the Ilkhan?

Imor was chafing in this new prison. He would go with the Viceroy to different hospitals and sit with him endless hours in learned doctor's waiting rooms. He would carry out patiently those innumerable minor commands. He had learned the appropriate mannerisms of the city folk. But he could not be one of them. It was no use, and he was looking for a way out. He could have found a way out and courageously faced shame and defeat, if fate had not led him to the local pharmacy one day.

One early morning, Imor entered the local pharmacy with the loud and pleasant "salaam" of people of the wide open tribal spaces. The pharmacist stared in disbelief at the strange but well proportioned figure. He pleasantly asked what the newcomer wanted. Imor said he had a letter to deliver. The pharmacist understood, and smilingly took the doctor's prescription. He guided Imor to a bench and bid him to sit down. Imor had never sat on a bench. Besides, he was never so impolite as to dangle his feet in front of others. He gathered his long robe around him, stepped upon the bench, pulled his legs beneath him and perched on top of the bench to the great amusement of the pharmacy apprentices.

The prescription was prepared, wrapped up, and Imor called for with warmth and politeness. The pharmacist inquired about his health and his tribal origin, showering him with verbal kindness.

That same afternoon, Imor returned to the pharmacy. This time he had no letter to deliver. The pharmacist was a wise man and understood. He invited Imor to come as often as he pleased.

Visiting the pharmacy became a pleasant pastime for Imor. He would come everyday and gaze in wonder at the rows and rows of jars, vials, boxes and bottles. Like a child beginning to talk, he would ask the names of each and every medicine and what it would cure. The odor inside the pharmacy was more appealing to him than any fragrant perfume he had ever smelled. It was a temple of healing, a holy shrine curing the sick and soothing the pained. All those wonderful remedies with so few patients here, and those countless patients in the tribe with no medicines at all.

Imor was innately kindhearted, and to repay the pharmacist for his kindness, he soon acted as the receptionist. He would sweep the sidewalk and sprinkle water in front of the pharmacy. He would often bring fruit and sweets from the Viceroy's rich table for everyone in the pharmacy.

One day something happened to raise Imor's standing in the eyes of the pharmacist. It was a quiet afternoon and the streets were empty. Along came a rider upon a beautiful horse. Imor was spellbound. He suddenly remembered his own horse-riding and then lost all control. In two or three jumps he caught up with the horseman, and after a profusion of pleasantries and entreaties, his proposal to ride the horse was accepted.

Like a child beginning to walk, he would ask the name of each medicine and what it would cure.

The rider came down and Imor was in the saddle with one graceful lunge. Two encirclements and the horse sensed who was riding it. The pharmacist, his apprentices, customers and a few passersby gathered to watch the spectacle. Imor dropped his handkerchief in front of the pharmacy and then cantered to the end of the street. Then he turned back. At first very slowly, then picking up momentum, he charged forward at lightning speed. He dropped the reins just before reaching the handkerchief. His left hand buried in the horse's mane and his body twisting around, his right hand picked the piece of cloth off the ground with the greatest of ease, gracefully throwing it to the sky. He reached the other end of the street and turned back again. In a fast gallop just in front of the pharmacy, at a twinkle of an eye, Imor was off the horse, twirled in the air and touched the ground with both feet and jumped again upon the horse! This was not riding a horse, but a falcon floating upon a zephyr.

Applause broke the after-silence! Now, the pharmacist lost control, and with tears in his eyes he embraced Imor as his own son, kissing him on both cheeks.

Imor's frequenting the pharmacy had its drawbacks. It had become irritating to his master. The Viceroy was sick and that made him more irritable. He wanted Imor in attendance and at attention at all times—there being a command or no command at all. Imor could not obey. The Viceroy's call would not reach him at the pharmacy. Not all of Imor's past and present affection and loyalty, nor his dread of the future, could keep him any longer from attending the temple of healing.

❦

AT LONG LAST THE VICEROY'S TREATMENT WAS OVER AND after many months the tribe prepared his welcome. The Viceroy reached Semirom by automobile, the very first of its kind seen in the tribe. The sight of the machine was a feast in itself. The throng of welcoming well-wishers surrounded their beloved leader, carrying him to his tent as a victorious conqueror. Everyone was present except Imor. Before reaching the tribe, Imor had been dismissed in rage and discharged in anger. And the first order issued by the tribal leadership—an order forever binding upon all—was that no one was permitted to take in this worthless, ungrateful scoundrel. Worse, no one should dare to intervene on his behalf to beg forgiveness.

Covered with dust and disgrace, with no one in the tribal capital he could turn to, Imor remembered that he was born in a far-off subtribe near Behbahan, called the Shahinlous. But now he had neither the strength to go there, nor the least expectation of being taken in by his poor tribal kin. The tamed desert gazelle had become ensnared by city kindness. He turned back to Tehran. The pharmacist was a wise man and understood. He took him in as his own son and set him off on his formal education.

Imor turned to the books. He reached for those magical letters of the alphabet. A capable body and a receptive mind, deeply in love with knowledge and charged with a purposeful drive, he galloped forward. Kept out of formal curricula because of age and background, but spared prescribed vacations and distractions, he surged forward in the saddle of study. In seven years he had earned his diploma. And then he entered medical school!

A few more short years and Imor was a doctor, a fledgling fish entering the vast ocean of medicine. The playful tribal orphan had reached the eminent rank of a physician.

The pharmacist could well see Imor, in time, an eminent physician in Tehran, treating the rich and the powerful. Imor saw himself in a small white tent treating the tribal sick and poor. The pharmacist was a wise man and understood.

And so, carrying a heavy load of pills, bandages, lotions, salves, injectable and edible medicines, and a much bigger

load of enthusiasm, Imor set off towards the tribe. Now he could turn towards his ancestral clan, knowing that he would be taken in, but not counting on any softening of spirit in the tribal leadership.



The Shahinlou clan, with more than a hundred household tents, was passing the second half of its summertime in the handsome "Lishter" plain, midway between Behbahan and Dogonbadan. Many clan members were blood relatives, all branches and twigs of an old family tree called Shahin. Few of them owned more than a hundred sheep.

They all lived in small black goat-hair tents, of a size barely allowing its inhabitants to move about and rest. There were no rugs on the tent floor. Simple cotton mats were too precious to be walked upon and were better used to cover meager food supplies. Some tents were so small that they could easily be carried by one donkey the length and breadth of the province.

There were no breakable dishes, cups or the like in the whole Shahinlou clan. Each household had its own few assorted copper kettles, a watering can, and some tin cups and plates. The household goatskin water bag, except for part of summertime, rarely held clear spring water. There were none of the colorful tribal rugs or gelims. The entire belongings of a household easily fit into a few worn-out bags.

There were no horses, camels or mules and none was needed to carry the light loads. A few donkeys and cows with their watch dogs were enough. And the latter could always fare better than people, as more sheep succumbed in dry seasons. In nature's lavish times, the Shahinlou clan had enough to live on their sheep. But when the sky became stingy there would be starvation. Then, in desperation, the clan would send its young men, armed with clubs and sticks and muskets, to wherever it had rained!



It was 50 days beyond winter solstice and little green stubs were all over the field. Dew moisture would raise them, but they were waiting the rains. The earth was breathing and the air was damp. An early spring was in the offing. Behind thorn bushes and around tree stumps, desert grass was ready for lambs but not yet for hungry sheep and grown livestock.

All eyes were fixed on heaven above. Clouds would come, cast their shadow and move on. Plains and mountains were ready to deliver lilacs and clovers if it rained. Just one rainfall! If only it came! Earth would become paradise. There would be milk in breasts. There would be yogurt, and the swinging tune of butter sacks. Moneylenders would arrive and there would be riches for all.

Tribal people had strange ways of appeasing and cajoling the sky to shed its water: A grown man would be decorated in a strange way with two horns in his cap pointing skywards, white lamb wool falling from his face as a bushy beard, his shoulders covered with a woolen shawl, brass pestles hung on his belt, and flour dust thrown over his body. He would be surrounded and carried from tent to tent, where he would chant: "I am Kouseh Galin, I have brought wind, I have brought rain, I have brought wind, I have brought rain."

At last there was rain! A black cloud rose and shed its plentiful white pearls. Flowers blossomed to the tune of songs and flute, merry at nature's long awaited wonder.



Merriment stopped abruptly with the barking of dogs. A stranger had arrived. The newcomer's garb, hat and boots were those of city people and he carried a bag in one hand. He stepped forward with a loud and pleasant "salaam." Everyone gathered around him. First making sure that he was among the Shahinlou clan, he asked in true Shahinlou Turkish dialect if anyone remembered the drought of some 20 years ago, or if anyone knew of a woman called Falak.

An old man stepped forward: "Yes, I knew Falak. She was my cousin. Many of us died in that drought, and others scattered and were lost. Falak, with her two sons Timor and Imor, took off for the desert. No one ever saw them again." The stranger took a deep breath: "I am Imor! My mother, Falak, and my brother, Timor, both died of hunger and thirst. I survived. I have now come back to be your doctor!"

Tears became mixed with laughter, and merriment resumed.



The very next day Imor, with some tribal youth, fetched his belongings from nearby Behbahan. Two small white tents were pitched, one housing Imor, the other his little clinic with its medicines, treatment mat and surgery. His savings of many years in Tehran was enough to buy a horse and a mule: one for him to ride, the other to carry around his little mobile hospital. And a few sheep, trusted to a shepherd, were enough to bring him his bread and butter.

Imor began his work with relish. At last he was where he wanted to be. He had found what he had been looking for. The son of mountains and deserts had returned home, with a deep love for his kin and a broad base to serve it. Riding on his skill, his spirit soared upwards. In less than two years, Imor's fame spread far and wide. The sick came and left well. Genies had to retire and experienced old women, skillful barbers and soothsayers lost their clients.

There were many in the tribe who lived on the ignorance and illness of others, and their number was not small. For as long as anyone could remember there were tribal people who had escaped the need to plant and harvest, to graze sheep and toil to live. Groups of sorcerers, magicians, spirit conjurers, prayer writers and genie-chasers lived on the illness of stricken tribal people. Nature's harshness drove tribal people to temples of these masters of the supernatural, where they were kept in helpless bonds.

The tribal path of migration, its winter and summer quarters, were littered along the way with little prayer posts. No valley and no mountain slope was without them. A little holy spittle and a few sacred ashes fetched a high price. Lonely trees along the way, casting shadows of good omen, had hundreds of colorful small ribbons fastened to their branches, each strip binding a pact with good fortune. The sick would rest in the cool shade of the tree and part with a felt promise of good health, leaving behind their little colored strips of sealed covenant.

A lonely star in the tribal sky, all powerful and vindictive, would never forgive betrayal. No traveler and no migration dared go against this one vengeful star. This one star would never rest, punishing mercilessly any defying traveler or migrating tribe. It moved each week of the month to a different spot, awaiting challenge. In the third week of the month, but especially on the 21st night of the month, its anger would peak. It was then that homes would be wrecked and families strewn to the winds. It was not for nothing that the most biting curse any Ghashghai could utter was "To be taken by the Star of the Twenty-first Night."

Groups of sorcerers, magicians, spirit conjurers, prayer writers and genie-chasers lived on the illness of stricken tribal people.

And all those poor, innocent star-struck ones had no choice but to submit. Only when their burden became unbearable, with their loved ones taken from them forever, would they reach at times for their guns and shoot in desperation at all the stars in the sky.

Each clan and subtribe had one or two wise men who knew the ways of the stars, and who could guide the rest. He who took off on a trip without such guidance was sure to lose his path. He would be bound to return to supplicate to the wise ones.

Next to such heavenly calamities rested an earthly one. This one knew no night or day, nor innocence or guilt, black or white. It was the evil eye.

There were those among tribal people whose glances were more penetrating and destructive than the fastest and sharpest of arrows. Its victims were the best of men, women and animals. The finest of the tribe and those whose deeds were best, were most likely to be hit and felled by one piercing glance of an evil eye.

Terrified mothers would cover long distances in search of a graced one, to secure a written prayer to ward off glances of evil eyes. No youngster, no beautiful horse and no tribal hero could afford not to be protected by such protective amulets.

And then there was Aal, that terror of all pregnant women of the tribe. Not a year would pass without the loveliest of all tribal brides falling victim to this vicious monster, who would feed on the liver of young mothers-to-be. It cared little for prayers, but was known to flee at times from those few courageous men in the tribe who had "Udum," the power of binding Aal. These men were said to have captured one of those rare genies and taken a few locks of its hair as a trophy. The presence of these men at childbirth was the ultimate defensive weapon. Their noise, their gunfire, their incantations and commotion attending childbirth was an impressive spectacle.

Even more astounding were rituals necessary to safeguard fortunate male offspring. Such rituals were the exclusive domain of experienced old women. With midwifery their undisputed right, these women had become, over time, guardians of the tribal health and well-being. Except for bone-setting, tooth-pulling and circumcision, tribal medical practice was a female profession. Armed with bottomless sacks of herbal and non-herbal medicaments, this elderly feminine caste took on the battle of any and all ills known to man and the supernatural. A frontal assault on sickness of the royalty, known perhaps in other circles as cancer, was their specialty. Invariably, and always towards the hopeless end, soothsayers, sorcerers and magicians would be called in for consultation.

IMOR COULD NOT HELP RAISING THE IRE OF THESE EXPERIenced old women, skillful barbers and soothsayers. Even more angered were the army of servants of the Ilkhan himself. Imor was a thorn in their side. The House of the Khan, the court, the tribal monarch himself—all three in one—depended heavily, if not solely, on dues levied by the Ilkhan himself. It was sheer and oppressive ransacking of the powerless by the powerful. The Khan's emissaries used every ruse to divest tribal people of the fruit of their labor and tribulations. And of all forms of taxes, none was more onerous than the herd tax.

In a narrow pass, a tribal flock would be held up, heads counted and, of every hundred sheep or goat, three or even four fat sheep and rams picked and taken away. The picking was never free of cursing and kicking and a cloud of dust. The Khan's men holding on to the rams horns and the shepherds pulling its feet—the former would always win out.

In one of these tax-collecting encounters, some of the braver young men of the Shahinlou tribe managed to stave off the Ilkhan's collectors. This was no small affair. The news spread fast and far, raising both praise for valor, and anger at such affrontry.

Doctor Imor was singled out as the instigator. Accusations were well prepared. This man, on the pretense of checking for fever, would hold young tribal girls by their hands! He would inspect the throat of tribal brides! He dared to attend childbirth in person! Imor was an agent of Tehran, and an agent of foreigners! He had been sent by the heathens to ruin tribal ways! He had no respect for the Khan and his hearth! He was impolite towards tribal chieftains! He would not go on pilgrimage. He would not rest under trees bedecked with prayers. He was an agnostic, whose blood it was safe to spill!

A vast army of hidden enemies of simple tribal people had found their single target. Imor knew well the danger all around him. He had realized that serving simple souls was not easy. He stepped softly, but would still arouse rivals. His very presence would enrage contenders.

Imor had spent the best years of his youth in Tehran. He had breathed in the air of freedom in the short interlude between the oppression of the Gajar and the repression of the Pahlavi dynasties. He had gone to school and read the classics, and it was unbearable for him to see the ensnaring sham and deception.

No sooner had snow on the peaks around Semirom melted away, and bubbling springs around summer quarters lowered to a trickle, than the fall migration began.

The weather was getting cold, and water in goat-skin bags would freeze. Of spring and summer greenery, only liquorice plants remained. But of no use to man or beast, they would stay untouched.

Everyone in the tribe was ready to move. A two-month journey lay ahead. It would take them over mountains, across plains, around passes. Many rivers had to be waded through. All this to escape the biting cold, the blinding wind and the burying snow, until warmer winter quarters were reached.

Autumn was the game season. Little quail chickens were now spotted. Little fawns had grown into hefty bucks. Hunters were shining their bullet-holders and polishing their shotguns to reflective brilliance.

Stablemasters were taking horses off clover and putting them on straw and barley. Hoofs were renailed; saddles and straps and reins greased and shined. All foot gear was mended. Pack saddles were stuffed with linen and cotton bits to avoid scraping the back and sides of donkeys and mules.

At last the mobile tribal capital was ready to leave its lovely summer quarters behind. Once again a colorful little city began to move. And once again men and women, old and young, sick and well, horsemen and foot travelers, brides and bereaved, canoneer, teacher, scribes, henchman and convicts, all making a colossal colorful caravan many miles long, would move on towards winter quarters. And once again those with pearl necklaces would travel alongside rows of prisoners bound together by iron chains fastened around their necks.

This time the row of prisoners was longer than usual. Most were on foot. Chains around their necks kept them not too far apart. Political prisoners and common criminals were now kept together. And among them there was a new face. He looked different from the rest and his gait was different. He had a penetrating gaze. But it was a sad and suffering gaze. His eyebrows were joined in the middle. His clothes were cleaner than that of fellow prisoners. Horsemen riding up and down the row of prisoners watched him more intently. He was Imor, Doctor Imor. Chained to many other prisoners, some ordinary thieves, some highway robbers, some freethinkers, he was being transferred to the fixed prison of the Ilkhan.

The Ilkhan's fixed prison was a labyrinthian stronghold called the Fortress of Paryan, perched on top of a hill near Gheir and Karzin. No one could remember ever knowing anyone who entered the Fortress of Paryan to come out alive!

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Malaria Scare

by H. Stanley Bennett



Above:
Village near Pagalo in up-country Togo.

THE SOUND OF A MOTO WITH A defective muffler wakened me from an uneasy sleep. Chalim, the Peace Corps driver, had arrived to chauffeur me from Togo to Cotonou in Benin. It would be a long day. While I ate breakfast and packed a few essentials for the African road, Chalim readied the battered Peugot 504.

"Chalim, isn't it too early for harmattan?" I looked up at the equatorial sun dimly visible through the Saharan dust brought from the north by upper atmospheric winds.

"Harmattan always start in November, doctor."

We left the dusty, pot-holed road in front of my house and turned onto the paved coastal highway. The road that fronted the ocean was full of battered taxis, heavy trucks, motos and people on foot hurrying to the marché. The surf pounded the steeply sloping beach, making it difficult for the fishermen to launch their dugout canoes.

"How long to Cotonou, Chalim?"

"Two, three hours, doctor. Depends on how long it takes to cross the border."

We were a strange pair. I was an aging American doctor trained at Harvard Medical School with more than three decades of internal medicine behind me. Now I was a Peace Corps physician, stationed in Lomé, Togo, with responsibility for 350 volunteers spread over three countries: Togo, Benin and Ghana.

Chalim was a Kabiye villager who had learned to drive. He had had years of experience on West African roads and had been employed by various foreign development groups. Though he was unable to read a map, he never forgot a place he had seen. His ability to find his way back to a small village, a back alley, or a remote volunteer's site was almost uncanny. He could recite the names of all the American presidents in order.

We headed east, parallel to the ocean, driving rapidly on a two-lane road well maintained with foreign money. Small thatched roofed villages stood among groves of coconut treees, which bordered the beach and were outlined against the sky. Near the road, long-horned African cattle grazed in the brush. Women and children offered various items for sale at the roadside: bananas, oranges, mangoes, sugar cane, fresh corn and pineapples.

"Get your passport ready, doctor, we are coming to the border." Trucks were lined up along the road waiting for clearance by languid customs officials. Vendors of all types of merchandise had established themselves along the road and under large baobab trees. Anywhere in Africa that traffic is momentarily stopped, a small city appears. Chalim's job was to obtain customs clearance for our vehicle—a small bribe expedited this process—and clear himself, a relatively easy procedure since he had an African passport. Because I was foreign, I had to obtain a visa. I approached an open building, where a row of officials sat behind a rough table, and joined a milling, pushing group trying to thrust their documents under the noses of the officials. Because I was white, my passport was accepted early. The boom was raised and we were free to move 100 yards to the Benin officials, where we repeated the whole process.

After the border, we drove along the costal plain through small villages, dodging goats and chickens. Only an occasional large boabab, with its typical bulbous trunk and large dangling fruit, rose above the thick brush and the fields of manioc. After a gentle rise we came to a large shallow lake extending to the north, not an unusual feature of this ancient peneplane.

The terrain was similar to that of Togo, but the condition of the road had deteriorated and the villages were shabby. Benin's Marxist dictatorship had succeeded in ruining its fragile economy and, perhaps more importantly, alienating potential donor countries in the Western world.

We entered the outskirts of Ouida, an old slave port and provincial capital. There was no time to stop on this trip but I had been here before. A Portuguese fort, centuries old, remained intact. Old cannon inscriptions, crumbling walls, and overgrown gardens testified to the slavers' presence in previous centuries. The beach from which the slaves were loaded onto the slave ships was nearby, though the sea had destroyed docks and buildings. This was the "slave coast" and departure point for hundreds of thousands of Africans destined for the plantations of the new world.

"Here's Cotonou, doctor." We entered this dreary city from the west and drove slowly to the center. The roads were choked with traffic, primarily ancient taxis and motorcycles. Passage through intersections was difficult; certain streets were blocked for the use of the president-dictator; pavement was broken or nonexistent. Pretentious but deteriorating government buildings lined the better streets near the beach and crude statues, testifying to the strength of the "revolution" and the power of the masses, were at major intersections.

"Chalim, I want to check with Nicole first, then I'm due at the ambassador's residence."

I found Nicole in the dispensary of the Peace Corps building. She had been given some basement rooms, which I entered through a low door. "Nicole, what's new?"

"Just more malaria, doctor. I'm getting pissed off at the volunteers who won't take Fansidar." Nicole, French Canadian, well-educated and well-mannered, had learned much of her English from the volunteers. She ran a good operation, was unflappable when stressed, and was experienced in handling the problems of the Peace Corps in Africa. As a competent nurse practitioner, she rarely called on me for help. "I hope you can persuade that doctor from Washington that we have a real problem here."

"I'm going to try, Nicole, but I'm not optimistic. You demonstrated chloroquine resistance here nearly a year ago and we did the same in Togo last spring, but Peace Corps Washington just acts as though they wish the problem would go away. We had 17 cases of malaria last month and some very sick. We're seeing fewer, but the rains are over and a lot of my volunteers are taking Fansidar."

After a few minutes spent reviewing the latest Peace Corps gossip, I hurried on to my meeting with the ambassador.

An African guard met me at the outer gate and turned me over to another functionary at the heavy, carved front door. "The ambassador will be here in a minute, sir." The residence, designed by a former ambassadorial wife (reputedly an Italian countess) was a masterpiece of glass, marble and fine woodwork. Handsomely landscaped grounds and a large swimming pool were visible from the ground floor reception hall. Sumptuous furnishings were in accord with the liberal allowances provided by the State Department to our overseas missions.

The ambassador appeared, followed by a well-tailored, middle-aged man, a physician sent from Washington to tour African outposts and educate foreign service personnel about AIDS and malaria. The ambassador and I were much concerned about the number of cases of malaria in recent months. The appearance of this man was at least partly in response to several urgent cables sent to Washington from the Benin embassy. Though advance notices had implied that he was a specialist with academic credentials, I soon determined that his medical school connections were some years in the past, that he now worked full time for the State Department, and that he had little clinical experience in tropical disease or malaria.

After a formal and nonproductive luncheon with young foreign service people, local Beninoise physicians and dignitaries, I had an opportunity to

meet with the visiting official privately. He had come prepared to talk about AIDS and was well versed in the latest statistics and research. He gave me a number of reprints of articles, which I had, for the most part, already read. I tried to explain that as far as I could determine, AIDS was not yet a major problem in this portion of West Africa, but chloroquine-resistant malaria definitely was, especially among Peace Corps volunteers.

"I have treated half my volunteers for malaria in the past nine months—some of them desperately ill—and I don't have facilities for hospitalization nor do I have the means to transport them from their remote villages. We may well lose someone. I have about half of the volunteers taking Fansidar regularly and this group is malaria-free."

"At the State Department we feel Fansidar is too dangerous," he replied. "There have been a half-dozen fatal skin reactions reported worldwide."

"I think the danger of death from malaria is greater than the danger of the reactions, especially in isolated volunteers."

"We recommend Paludrine, the old British drug, for prophylaxis. It is quite safe."

"Safe, perhaps, but in my experience, of little help," I argued. "I have given it to about 50 volunteers; half came down with malaria."

"Sorry, we can't back the use of Fansidar. Too much possibility of legal action if anything goes wrong."

"If someone dies of malaria, is there less chance of legal action? What are you taking while on this trip, doctor?"

"On the advice of our tropical disease people, I am using mefloquine but, while it is quite safe, it hasn't been FDA-approved and we can't release it for use in the field."

On the trip home, I reached some conclusions: Washington didn't comprehend the problem or fully understand how poorly equipped we were to treat our worst cases. If I used Fansidar for prophylaxis, I was responsible for bad results. If I didn't, I might lose

If the epidemic continued at its current pace, the Peace Corps program in this part of Africa might be in jeopardy.

some of the people under my care. If the epidemic continued at its current pace, the Peace Corps program in this part of Africa might be in jeopardy. Something had to be done before the rainy season began in the spring.

The dry season was well under way as Christmas approached. There had been no rain for six weeks; dust from harmattan reduced visibility to a couple hundred yards on the worst days. Already the farmers had started to burn their fields as the first step in preparation for spring planting. About once a week, a volunteer would appear shaking and prostrated by malaria, often spending eight to ten hours packed in a bush taxi in order to come to Lomé and medical attention. Clearly those who followed my recommendation to take Fansidar prophylactically were avoiding malaria, while those who had listened to governmental warnings about the drug and refused to take it were contracting the disease.

Freda, the Ghanian midwife-nurse, and Sheila, the British nurse practitioner, had become well acquainted with the clinical picture of malaria and adept at treatment. We had worked out various regimens designed to fit the severity of the particular episode, and had learned the signs and symptoms of this multifaceted disease. Some had very high parasite counts; a few were jaundiced; many had evidence of red blood cell destruction, an ominous sign. We were amused by the criteria established in the American medical literature for admission of the malaria patient to an intensive care unit. Many of our patients fulfilled the criteria, but the closest intensive care unit was thousands of miles away.

We had two beds in a back room of the clinic. It was a dingy, poorly lit room furnished with ancient beds and piled with the luggage the volunteers brought with them. We gave intravenous quinine when necessary and provided round-the-clock nursing on occasion, but most of the time the patients were expected to look after themselves and even administer their own medicine. Food came from a nearby Chinese restaurant and was often unsuitable for a patient with a temperature of 105 degrees and a queasy stomach, but when the volunteers complained, we pointed out that it was Chinese or nothing.

Sheila and I conducted a vigorous campaign to persuade the volunteers to take Fansidar and to carry out a careful program of mosquito control at their sites. The training site at the upcountry village of Pagala, where all new volunteers spent three months learning French, had provided many of our patients. Site spraying, screening, repellents, and Fansidar reduced the incidence from this area to a minimum.

By February I thought we were over the worst and in control of the epidemic. The volunteers now knew that they must come to Lomé promptly for treatment, and only rarely did they prescribe for themselves and ride out an attack in their isolated villages. Still, some of our patients were very ill and the margin between rapid recovery and disaster was small.

Early in May Sheila announced, "Doctor Bennett, I'm going to take my vacation next week. I'll be gone for five weeks."

Sheila always disappeared on vacation with little warning and without prior clearance from me. Her interpretation of time due her was generally more liberal than her contract allowed.

"Every time you leave, something bad happens and I get stuck with it.

Still, it's better to get it over with before the rains come and the malaria picks up."

This was Africa; Sheila worked devotedly long hours and, like all of us, needed more time away from Lomé than we were entitled to.

"Okay Sheila, have fun. We'll hope nothing happens."

A few days later the office phone rang. It was Dave Jackson, the "gunny" sergeant who served in loco parentis for the six young marine guards at the embassy. "Doc, I've got a sick marine here. He has been throwing up and chilling all night."

"Bring him over to the clinic."

"He's too sick to move. You better come over here."

"I can't do much for him there. He'll survive the trip."

The marine house was on the other side of town—a well appointed mansion in which the detachment lived, serviced by a staff of Togolese. The United States government here, as elsewhere, spent large sums to maintain the morale of the marine guards who were, for the most part, poorly educated late teenagers, survivors of marine basic training and a year of stateside service. Their main concerns were a rigorous schedule of physical training, strong drink, and the local women. The embassy community by official policy included the marines in most social events, where they usually behaved well and socialized enthusiastically with the teenage daughters of State Department officials.

"Dave, which one of your boys is it?"

"Mike Kelly. He's always sick."

This, of course, wasn't true. He was in excellent health and had the body of a well-trained athlete, as did his fellows, but I had treated him once for severe dehydration, incurred when he lay ill with dysentery in the marine house, unattended for several days. He was a pleasant, shy youth, cooperative and undemanding as a patient.

Mike was miserable. He complained of severe headache, chills, nausea and abdominal pain. Freda, the Ghanian English-trained nurse, took charge. She was an attractive, pert 38-year-old, whose competence had previously been overshadowed by Sheila. She put the marine to bed, started intravenous fluids, and summoned Philip, our large, taciturn laboratory technician. Philip was African-trained and though I knew he was accurate with malaria smears, I had reason to doubt his competence in other procedures, such as stool examinations and blood typing.

Here I was, unable to establish the diagnosis and reluctant to consider surgery under the primitive and dangerous conditions of the Lomé City Hospital.

Philip soon reported that the malaria smear was positive, 3 percent—not an unusually high level but a substantial infection. It was unusual for expatriates in Lomé, who lived in screened houses and took reasonable precautions, to contract malaria. Reasonable precautions for city dwellers included the prophylactic use of chloroquine and Paludrine or Fansidar. I discussed this with Dave and found that the marines only used chloroquine, and that due to two damaged screens, swarms of mosquitoes had invaded the marine house for several nights two weeks before. The incubation period for Falciparum malaria is two weeks.

I started quinine and Fansidar and outlined intravenous fluids for the next 24 hours. Freda and Mary, the Togolese back-up nurse, began double shifts. Philip found normal blood counts and a steady decline in malaria parasites on succeeding smears. Mike remained quite ill and my concern over his lack of progress mounted. But, I knew the course of malaria was unpredictable and the sufferer's response was often unrelated to the degree of parasitemia. I had treated volunteers who, with the same degree of parasitemia as Mike, were barely ill and returned to work on the third or fourth day.

On the fourth day, Philip reported Mike to be parasite-free, but he remained bedridden, pale, nauseated, and he complained of abdominal pain. I encouraged him to get out of bed but he felt faint when he sat up and required help to get to the bathroom. Late that afternoon I conferred with the nurses. Both of them had seen a great deal of tropical illness and shared my apprehension, but had little to offer.

My supper was interrupted by the arrival of a breathless Togolese guard who had sprinted the three blocks from the clinic to my house. Mike had collapsed in intense pain on the way to the bathroom but had managed to attract the attention of the guard at the gate.

I found Mike in great distress: rapid pulse, falling blood pressure, and a rigid abdomen—all signs of an intra-abdominal disaster, but there was nothing to indicate which of several possible diagnoses was responsible. Mike was in pain but not apprehensive; he felt he was in good hands and that modern medicine as personified by me and the staff of our primitive clinic would see him through. I wished I shared his serenity about the situation.

Philip rapidly determined that Mike's red blood cell count had dropped significantly—either a sign of internal bleeding or a result of red corpuscle destruction by the malaria parasites. Freda reported that Mike's blood pressure was falling but could be maintained by running intravenous fluid at

a rate faster than could be sustained for a long period.

In an American hospital I would have moved Mike promptly to an intensive care unit, ordered several sophisticated diagnostic procedures, arranged for consultation, and eventually made a decision as to the necessity for emergency surgery. Here I was unable to establish the diagnosis and reluctant to consider surgery under the primitive and dangerous conditions of the Lomé city hospital.

Finally, I decided to call Kossi Homawoo, a genial Togolese orthopedist and general surgeon. Trained in Ghana and France, he possessed the best background available here; furthermore he spoke English and I was far from fluent in French. He valued his contact with the Peace Corps and the American community, and had been helpful in the past. I knew and liked him, but had doubts about his surgical judgment and technical ability. He had been to our office many times for consultations or to cadge supplies for his office.

Dr. Homawoo arrived promptly and agreed the problem was serious, but could contribute little to the diagnosis. I knew from my reading that spontaneous splenic rupture, a condition ordinarily mandating immediate surgery, could occur in acute malaria. Dr. Homawoo dismissed this possibility; he had practiced in Lomé for 25 years, had encountered malaria literally thousands of times, and had yet to see such a case.

He suggested we take the marine to Centrale Hopital Université, the city's only hospital: a large sprawling, dirty, under-equipped and under-manned institution. The trip to Adeta, where an American Baptist surgeon ran a small hospital, was out of the question due to poor roads, darkness, lack of vehicles, and the poor condition of the patient. Having no other recourse, I agreed.

Dr. Homawoo obtained the use of one of the hospital's two ambulances. We loaded Mike into this ancient vehicle and, with Mary accompanying him, sent him off through the crowded, dark streets to CHU. I directed Freda to start locating suitable blood donors and Philip to stand by for cross matching. I followed the ambulance in my Peace Corps Peugeot, pushing through the traffic and dodging pedestrians.

Whether Mike lived or died might well depend on decisions I would make in the coming hours and I wasn't confident. Surgery at CHU could only be elected as a last resort, but evacuation to Europe would take more time than we might have. My anxiety peaked in contemplation of this catastrophe, but

Below:
Peace Corps intensive care unit.



as has happened in the past, I knew it would diminish when action became mandatory. It was late at night and I was tiring, but surely would be up all night. A younger man with good surgical training, as opposed to my experience in internal medicine, might handle this situation with a better chance of success.

At the main gate of the hospital the usual crowd of patients and relatives, beggars, vendors, police and loafers parted to let me pass. The ragged gatekeeper lowered a chain and I drove in. The hospital—low buildings spread out over two city blocks, separated by dusty courtyards—showed few lights. I parked, walked through the chaotic emergency-admitting area, and in the dark eventually found my way to the x-ray department, only because I had been there before in daylight and had memorized the paths.

The technician, urged on by Dr. Homawoo, had already taken several views of the abdomen, while Mike lay groaning on the table, showing signs of respiratory distress. The equipment was ancient and little effort was made to shield patient or technician from harmful radiation. We lifted Mike back onto a blood-stained stretcher and examined the x-rays, still wet from the developing tank. No help. The films were clouded and the patient had been poorly positioned.

"Dr. Homawoo, he looks to me to be dying," I said. I was truly alarmed by his paleness, rapid pulse, rapid respiration, and lack of coherence when questioned.

Dr. Homawoo agreed and for the first time showed some agitation. He had been in high spirits, testing his English by speaking of the "enigmatic abdomen" and making humorous remarks unsuitable to the occasion. He quickly obtained a battered tank of oxygen and agreed that we should increase the rate of intravenous flow. In addition, he installed a Foley catheter in Mike's bladder, a measure that hadn't occurred to me but which resulted in a copious flow of retained urine. Mike's condition stabilized and since we were no closer to a diagnosis, we decided to observe the patient for a time. Observation in medical parlance often means procrastination because we don't know what else to do.

Dr. Homawoo obtained a room for Mike in a nearby surgical building. It was locked and the daytime supervisor had gone home with the key. We obtained entry after a long delay, during which Mike lay on the filthy cart while Mary watched anxiously at his side. Eventually we got him to bed in the observation room, which we found dirty, sheetless and unaired. The window air conditioning unit, an unusual luxury in an African hospital, didn't work; light was provided by a single 40-watt bulb.

Post-operative patients occupied the rest of the floor in large wards. There were no sheets on the beds and family members squatted in attendance on the floor. Patients of all ages, both sexes, and with a wide range of conditions lay largely ignored by the night shift of nurses. African nurses are poorly trained and poorly paid. Families provide most of the personal care for the patients and bring them their meals from outside the hospital.

The night nurses were sleeping on the floor or on the counters in the service areas. They roused long enough to regard us with curiosity but didn't offer any assistance.

I had encountered a French surgeon on one of my previous visits, a man assigned by the French government to teach in the embryonic medical school and to perform difficult surgery to the extent that the facilities would permit. His parting remark had been, "If you need surgery, don't have it done here." At my insistence, he was called for consultation. He agreed with Dr. Homawoo that surgery should be deferred and blood transfusions withheld because "we might need it later."

The night slowly passed. Mike remained in precarious condition, barely conscious, but in little distress. I returned to the clinic to get sheets, towels, soap, water containers, syringes, intravenous fluids, bedpans and other basic hospital items.

Freda had assembled all the embassy people whose blood types matched Mike's and who passed certain criteria designed to eliminate the possibility of AIDS. In selection of donors, sexual orientation and promiscuity were major issues. She had obtained four units of blood from those who passed the tests and Philip was at work in his small cluttered lab typing and cross matching. Inaccuracy on his part—and I didn't really trust him in this area—could lead to a fatal transfusion reaction.

Since the hospital lab was closed all night, I had to send Philip to the hospital to do routine blood work. By sunrise he reported that Mike's red cell count had fallen further but not as much as I anticipated. Judging more by Mike's clinical appearance than the lab results, I felt he needed blood. I directed Freda to give him two units and hold the other two in reserve in an ancient refrigerator that we had found in a nearby building. While she did this, I started the tortuous process of calling an ambulance plane from Switzerland to take Mike to a large army hospital in Frankfurt.

The gunny sergeant and the executive officer of the mission had shown little interest in the crisis, but when I managed to find them, proved willing to cooperate. I provided them with information on whom to call and where to start. They needed clearances from the Marine Corps and the State Department, and eventually it was necessary for me to have a long conversation with a medical officer in Europe to justify this expensive flight. The plane then left Europe promptly to begin its seven-hour flight to Lomé. After one hour on the ground for refueling, it would return to Europe and Mike would be hospitalized about 25 hours after the evacuation was initiated.

Following the transfusions, he improved to the point that he could

take liquids and talk coherently. He had little pain and there was no further fall in his red cell count. I even began to wonder whether the emergency flight was justified.

The ambulance plane arrived about midnight, and the marines loaded their comrade into a four-wheel-drive vehicle for the drive to the airport. He was in good spirits when I turned him over to the doctor and nurse on the plane—a small, well equipped intensive care unit. I gave them the remaining two units of blood for use on the trip back to Europe if necessary.

I learned later that his condition became critical during the flight and that he was in poor condition when he arrived in Frankfurt, despite the use of more blood transfusions. The physicians in Frankfurt quickly established the diagnosis of splenic rupture by CT scan and performed emergency surgery to remove the spleen. The post-operative period was complicated by a recurrence of the malaria and by a large amount of pleural fluid, probably related to the massive amounts of fluid we had been forced to use. He survived and was promptly discharged from the Marine Corps.

Dr. Homawoo presented this case to an amazed conclave of his colleagues who, like him, didn't believe this could happen in malaria. Retrospectively, I knew that we should have operated immediately, regardless of the risks of surgery at CHU, and that only due to good fortune did Mike survive. There was no doubt in my mind that the blood transfusions we gave him, risky though they were, maintained him for the long flight back to Germany.

The rainy season began on schedule and with it appeared the usual swarms of mosquitoes. More patients with malaria appeared in our clinic, but they were people who were not taking Fansidar—volunteers, other expatriates, and Togolese who worked for the Peace Corps and hence had a claim on our services. I learned of deaths among expatriates in Lomé and

The night nurses were sleeping on the floor or on the counters in the service areas.

Cotonou and of an embassy dependent evacuated to Europe from Accra. None was taking proper prophylactic medication by my criteria.

North of us in Niger, chloroquine-resistant malaria came later but abruptly. The Peace Corps physician in Niamey (capital of Niger) was new and inadequately briefed in Washington on the epidemic nature of the disease. She evacuated several volunteers to Europe before the situation was controlled.

In mid-summer I returned to the States with my wife, who required an operation. The nurses, left on their own, treated several people with malaria; most were routine but one woman, an American teacher who had stayed to live with a Togolese man, contracted hepatitis B from him and at the same time had acute malaria, a dangerous combination. All did well under the treatment regimens we had established. By then we were using mefloquine in selected cases with good results. When I returned, the rains were nearly over and the disease was waning.

In December I relinquished my position. My successor arrived for orientation two weeks before my departure. I tried to summarize for him my two and one-half years experience with the Peace Corps and malaria, but he remained bemused by the cultural transition he was experiencing and the primitive nature of our medical organization. I tried to reassure him and urged him to listen to the counsel of the nurses, who were by then well experienced. I could remember my own state of mind in the weeks following my arrival, when the medical department disintegrated and the malaria epidemic began.

The new doctor remained in Togo about three weeks after I left and then resigned his job and returned to the States. The medical units in Ghana, Togo, and Benin were unsupervised for seven months before another physician was found.

Of the problems I faced during my service in Africa, malaria was the most persistent and posed the greatest threat to the health of the volunteers. In dealing with it, I learned a great deal about one of the world's most lethal illnesses, and through trial worked out some practical methods of control. I made some mistakes, had some useful insights, spent a number of sleepless nights, and through good fortune had no irretrievable disasters.

Now at least two new medicines are available, the volunteers' houses are screened, the training sites are better constructed, and the medical personnel are experienced in recognizing and treating acute cases. The Peace Corps will continue to operate in West Africa though, to my mind, the issue was in doubt for a time.

H. Stanley Bennett '45 was a Peace Corps physician in Africa from 1986-89, after retiring from 31 years of private practice in Taylor, Michigan. Since 1989 he has lived in Lake Oswego, Oregon, where he currently works in clinics for the homeless and indigent.

The Making of a Medical School

by Rodolfo E. Herrera



Above:
The medical school of Universidad Francisco Marroquin.

AFTER LIVING FOR 13 YEARS IN France and 13 years in the United States, I as a young surgeon returned home and found myself a stranger in paradise.

Paradise it was, because Guatemala is a beautiful country, and paradise also because in 1948 there was an opportunity to transplant and implant what had been learned at MIT, HMS and MGH onto a receptive and needy field.

A stranger I was, because Guatemala was a new world culturally, socially, politically, economically and medically. Even the omentum had to be called "epiplón" and the spleen "bazo."

What better example of the situation than to describe my first local appendectomy. The patient was an alcoholic who had travelled for four hours on a bumpy road to reach the "Casa de Salud" of a colleague, without sobering up, and presented with a rigid abdomen and generalized peritonitis. ("Casa de Salud" or "Maison de Sante" is an area adapted for hospitalization of patients out of a private home of a physician and his family.)

The anesthesia was given by a practical nurse using an Ombredanne apparatus (out of a museum), and the patient was blue during most of the operation, although he did not give a history of having been a blue baby! The instruments were boiled and Guatemala City is 5,000 feet above sea level; the catgut tubes floated on a brownish solution like a senior citizen on a Florida swimming pool, and the linen came out of paper bags. After several bouts of delirium tremendissimum, an infected wound and a pelvic abscess, which had to be drained through the rectum, both the patient and the surgeon recovered, eventfully.

By the end of 1948 a small group had been brought together and a small "clinic" was rented and organized with

two MGH nurses (Dorothy Hansen from White 9, and Mary Kirk, an anesthetist trained by Harry Beecher and Francis Foldes), bless their souls! And my Steele instruments enjoyed typical MGH autoclaving in large packages wrapped in cloth. Between 1948 and 1953 my first group of colleagues included an internist trained at Western Reserve, a urologist trained at Boston City Hospital, an oncologist trained at the Memorial in New York, and an ob/gyn surgeon trained at the Mayo Clinic. Guatemala's first peroperative cholangiograms (not learned at MGH) and lobectomies, pulmonary azygos anastomosis and mitral valve valvuloplasties (learned from the respected Richard H. Sweet and pioneer Dwight Harken) were performed in those years.

A new hospital with 50 beds was constructed and inaugurated in 1953. Some medical students and young graduates from the National University of San Carlos (founded in 1676) worked as interns and residents, our Centro Médico had good laboratories and x-ray equipment, and all the specialties were covered satisfactorily. But 10 years later when our ex-residents returned after their own U.S. training, internal disagreements unfortunately split the original group.

In 1963 a new association was created, with young physicians: an ENT man and an ophthalmologist trained at Massachusetts Eye and Ear, a cardiologist trained at Boston City, together with a hematologist, a pathologist, a neurosurgeon and a radiologist trained at MGH, an internist trained at Columbia, and a gastroenterologist trained at the Lahey Clinic. In 1976 our new hospital had grown to a 90-bed capacity with ultrasound, scanning, computerized tomography, a residency program in medicine, surgery, radiology and ob/gyn and, since 1991, endoscopic cholecystectomies have had us "à la mode."

The idea of utilizing our facilities, professional competence, and up-to-date equipment for teaching at the undergraduate level was born and it was easy to conceive a structure similar to the French CHU (Centre Hospitalier Universitaire), but we needed the umbrella of a university. When we approached the existing private universities, the answer was always "no, because a medical school is too expensive." But in 1972 a new progressive, private university was founded, Universidad Francisco Marroquín, and our proposal for a new medical school was presented, immediately accepted, and supported with enthusiasm by Foundation Chusita Llerandi de Herrera, named in memory of my mother.

HMS and MGH were great. Yes, the education and training were superb, but there was no course in the planning of a medical school, nor a surgical procedure to prepare for such an undertaking.

But first things first. Why a new medical school in Guatemala if there already was one, and in a country with a total population of less than six million, more than half of whom are illiterate?

In the year 1950, at the National School of Medicine of Universidad de San Carlos, the number of students entering the first year was around 150. At the end of six years, the graduating class numbered around 60 to 80. Then and now, to enter you must just apply; there is no entrance examination. By the year 1970, the number of applications had risen to more or less 2,000 per year. Medicine was and still is an attractive profession for a young high school graduate, no matter how immature.

Throughout Latin America it is usual to enter medical school directly after the last year of "bachillerato"—equivalent to high school. The result of the proliferation of first-year medical students was that a great number of MDs were poorly trained. And although the objectives were to raise the proportion of physicians to more than 800 per 10,000 inhabitants, most of the graduates remained in the large cities and found themselves without adequate work. The largest proportion of the population continued to lack primary care and adequate medical treatment. A new medical school was needed, based, as in France, on an existing high-quality hospital, and in the countryside, on primary care requiring "health promoters" (barefoot doctors).

I started on a trip to visit U.S. medical schools old and new. HMS and Dean Tosteson were my first stop. Then came Western Reserve, the community-oriented schools of northern Ohio, and McMaster in Canada. The curricula of some European schools were also obtained and reviewed.

A circular was sent to the members of our hospital staff asking if they would participate in teaching the clinical sciences (only three said no) and we approached Universidad del Valle, a private university attached to the American School of Guatemala, for the teaching of the basic sciences. Their acceptance and high academic standards allowed us to open the new medical school in 1978. During the next three years, we were able to build and equip our institution with the support of Foundation Chusita Llerandi de Herrera.

As previously mentioned, Latin American medical schools generally have a six-year curriculum, which includes premedical years: students are accepted directly from high school without an entrance examination. This creates the inevitable large desertion rate; out of a class that begins with 2,000 students, fewer than 10 percent will graduate in six years. We found that 60 first-year students, out of about 250 applications, was an adequate number for our future facilities. Roughly one out of three candidates accepted is a woman.

The buildings were designed by two Harvard University School of Design graduates, and on the land next to our hospital, in the midst of trees and flowers, was assigned space for

laboratories, an anatomy amphitheatre, an auditorium, classrooms and an animal farm.

It grew together into an attractive complex. The equipment was obtained through several channels: microscopes were imported from Poland with the help of UNICEF, chairs and furniture came from Canada, physiology and pharmacology apparatus were bought from the United States, and dissecting-room tables were built locally. After searching for a dean, the two Universities del Valle and Francisco Marroqúin named me for the post. A board of directors was formed with a pathologist, a psychiatrist, a pediatrician, and a neurologist—chosen for their idealistic views, their academic reputation and their willingness to work without remuneration.

The curriculum design is a classical one with a few adaptations to our local idiosyncracies: included are anthropology, history of medicine, bioethics, legal medicine and a six-month rural practice in primary care during the next to last year. In 1982 we took over responsibility for teaching the basic sciences, mostly for economic reasons, and the pensum was increased to seven years. (A dental school founded in 1983 also depends on us for teaching basic sciences for their first three years.) As of this year, we have added (like the old French PCB) a premedical year so as to level the aptitudes of our applicants.

Finances have prevented us from having many full-time professors except for physiology, pharmacology and rural medicine; the rest of the faculty is made up of practicing physicians who dedicate themselves part time to the school. Their compliance with assignments is closely watched, and we have recognized that their motivation is exceptional. Few changes have been needed.

The large public hospitals, including the Social Security Institution, contribute to the clinical training of our students. Monthly panels allow students to discuss their doubts with specialists they choose, and a faculty adviser is assigned to every student—the same physician who interviewed the candidate at the time of his or her application evaluation. Electives are introduced for two months during the sixth year.

We are indebted to HMS (with the good help of Guillermo Herrera), and to University of South Alabama (thanks to Sam Eichold, professor emeritus) and to medical schools in Germany, Holland and Canada, to mention but a few of the medical schools who have exchange programs with us. Our contribution to student exchanges is a rural tropical medicine

Below:
Professor Rodolfo Herrera stands with honorary professorship recipients, including George Nardi, Dean Monsaingeon, Aldo Castaneda, and Manuel Ayan, president of Universidad Francisco Marroquin.



elective for two months. Exchanges have opened possibilities for postgraduate training for some of our young MDs. And a great stimulus to our faculty and students was the recognition of our medical school by the British Medical Council after a valuable visit and careful evaluation by their representative, the dean emeritus of Kings College, Professor Cotton.

For the graduation exercises, our Hippocratic Oath is a slightly modified version of that used in Montpellier. For commencement, we have invited outstanding speakers: André Monsaingeon, dean of Paris University Medical School; Aldo Castaneda, Ladd Professor of Surgery at HMS; Michael De Bakey, chancellor of Baylor School of Medicine; and George Nardi, clinical professor of surgery at HMS (our dear departed friend). The graduation at Universidad Francisco Marroquin is an elegant academic event with occassional Harvard cap-and-gown colors in the faculty's procession.

Our Alumni Association is a very young and modest organization, which should help in the progress and future of the medical school of our respected patron, Universidad Francisco Marroquín. Its *Medical Bulletin* may some day resemble perhaps our own HMS *Alumni Bulletin*.

This quetzal bird's-eye view of the Faculty of Medicine of Universidad Francisco Marroquín (the quetzal is a bird, the national emblem, and the monetary unit of Guatemala) would be incomplete without a few lines about the fees that our students must cover. For the first six years the yearly tuition is 5,800 quetzales ($1,200.00). The last year of rotating internships has a cost of Q. 3,400.00 ($700.00). Why be surprised? The first-year tuition for our HMS class of 1942 was $500 per semester and lunch at Vanderbilt Hall was 65 to 75 cents—I still have a menu!

About 35 percent of our students receive education loans (partial or total), which are reimbursable within a specified limit of time, after their graduation.

And finally, how do we critically judge our Guatemalan creation? The ECFMG results, the top local residencies obtained by our graduates, the evaluation reports during electives abroad, and the quality and ethical performance of our young alumni, now in practice, are a few thermometers at our disposal. But we must remain humble. We may not be able to pride ourselves on having Nobel Prize winners to decorate the front cover of our *Alumni Bulletin*, but we hope to improve the health of our people in the course of the next decades.

Gordon Seannell '40 once wrote that "People have birthdays. Institutions have centennials." We trust that celebrating a quarter centennial, in the year 2003, is an acceptable objective for the Guatemalan connection.

Rodolfo E. Herrera '42 is professor of surgery and dean of the Faculty of Medicine of Universidad Francisco Marroquín in Guatemala.



Gypsy Doctor

by James D. Thomas

ONE OF THE RITES OF PASSAGE FOR incoming interns at Massachusetts General Hospital is to pick up a number of clinic patients left behind by departing senior residents. Among the patients I inherited when starting my primary care/internal medicine residency in 1981 was a 42-year-old woman with systemic lupus erythematosus, chronic renal failure with a creatinine of 6.0, severe hypertension requiring four drugs to control, and a past history of two myocardial infarctions and a stroke.

She was also a Gypsy. At the time I was completely unaware of Gypsy culture, thinking the term itself referred simply to any itinerant. My ignorance was to be short-lived, as this woman soon brought her brother to see me, who brought his son, who brought a cousin from Philadelphia, who brought a number of other family members. Indeed, over the next three years, I became immersed in Gypsy culture while caring for over 60 of them as inpatients and outpatients.

I felt quite honored to be welcomed into a society that is generally kept hidden from the rest of the world. Even my future wife, Donna, became caught up in this experience, since many of our early dates were to Gypsy death feasts. But more on this later!

When I looked into the history of the Gypsies, one of the first facts I learned is that Gypsies are a distinct racial group, tracing their origins to the Punjab region of India. No one knows why, but about 1,000 years ago they began a gradual migration westward, arriving in the Balkans by about 1400. It was here that Europeans first encountered them, leading to the misnomer Rumanian Gypsies.

Admission to the hospital is one of the most turbulent times in a Gypsy's life.

Their Indian origin is supported by their distinctive blood group and HLA phenotypes, as well as their unique, unwritten language, *Romani*, spoken by Gypsies throughout the world. *Romani* is similar in its grammar and vocabulary to Hindi, so much so that one of my fellow residents, an Indian, found that he could communicate somewhat with the Gypsies in their own language.

Between 1400 and 1600, Gypsies overspread all of Europe and first began arriving in America from Eastern Europe in the 19th century. The family I had the most interactions with could trace their origins to Bimbae Bimbo, a prominent Russian Gypsy of the last century. In the late 19th century, he moved his family to Argentina, from where they migrated to the United States in the 1920s. For the last 40 years or so, this extended Gypsy family, or *vitsa*, has been loosely grouped around the Boston area, though with many month-long sojourns around the country each year.

When I asked one of my patients why they travelled so much, he replied with perfect logic, "We're Gypsies. That's what we're supposed to do."

To understand contemporary Gypsy society, it is useful to know some *Romani* terms. An adult Gypsy male is called a *rom*, while a woman is a *romni*. Any non-Gypsy is given the pejorative term *gajo* (female, *gaji*; plural, *gaje*). A Gypsy household, or *familia*, typically includes six to fifteen individuals spread over three or four generations. Within a geographic area, several hundred *familiyi* will join together to form a *kumpania*, or Gypsy community. The other important family grouping is the *vitsa*, a group of several thousand Gypsies related patriarchally and scattered around the United States.

Gypsy life is intensely centered on the family. This indoctrination begins early, with toddlers joining in all *kumpania* festivities, which often last well past midnight. Children typically attend grade school sporadically, many never achieving literacy. By the early teen years, schooling generally stops completely, and the children become fully integrated into the economic and social life of the *familia*.

It is at this age that children enter

Opposite:
Gypsy children



into marriages arranged by the parents, involving the payment of money by the groom's family to the bride's. Typically, these payments will run approximately $10,000 for a "young virgin from a good family," but if she has a speech impediment or similar handicap, the price can often be bargained down.

Gypsy weddings last three days, and the bride and groom, though usually second cousins or closer in relation, may be barely acquainted before the ceremony. Not surprisingly, divorce is common in these marriages, with relatively little stigma attached to it other than a demand for partial refund of the bride-price if the breakup comes too soon.

As close as I became to the Gypsies in other ways, I never felt that I had a full understanding of their finances. Most of the women operate fortune-telling booths, which provide a small but steady income, supplemented by the occasional sting of a guileless *gaji*. The men work for themselves, running autobody repair, roofing and black-topping operations, though by their own admission, actual work is spotty indeed. Many are on some form of public assistance, and there is apparently some involvement with organized gambling.

Though they clearly seem to have a talent for tricking people out of their money, they are averse to violent crime and rarely have serious trouble with the police. Of great assistance to the Gypsies is a remarkable talent for outwitting the credit system. Though completely illiterate, one of my patients could tell me not only when her telephone would be disconnected for lack of payment, but also the number of the new line that would take its place!

In contrast to this somewhat shady relationship with the *gaje*, within their own community the Gypsies maintain a strict code of ethical conduct. Termed *romania*, this moral code divides the world into things that are *wuzho*, or pure, and those that are *marime*, or polluted. In general, life outdoors is considered *wuzho*, whereas indoors is considered *marime*. The upper body is considered *wuzho*, while the lower is *marime*, leading to the curious practice of having separate wash basins for upper and lower body clothes.

Even my future wife, Donna, became caught up in this experience, since many of our early dates were to Gypsy death feasts.

Throughout the Gypsy nation (numbering approximately a half-million in the United States and several million worldwide), there exists a sophisticated legal system to enforce the Gypsy moral code. After passing through several appellate tribunals, a case may ultimately reach the *kris romani*, a sort of Gypsy supreme court consisting of *vitsa* elders from several states.

Though they maintain their own internal religious beliefs, including a god, *o Del*, and a devil, *o Beng*, operationally they tend to take on the trappings of whatever orthodox religion is practiced in their community. Thus, in the United States they tend to be orthodox Catholic, although increasingly Gypsies are describing themselves as "born again." In other countries around the world, however, Gypsies practice versions of orthodox Judaism, Islam, Hinduism and Buddhism, all with elements of their own internal beliefs.

My initial encounters with the Gypsies naturally centered around their medical problems, and the group I cared for displayed an incredible array of premature vascular disease, hypertension and diabetes. Of the 58 whose medical histories I tabulated, hypertension was present in 73 percent, diabetes in 46 percent, occlusive vascular disease in 39 percent, hypercholesterolemia or hypertriglyceridemia in 94 percent, and chronic renal insufficiency in 20 percent, including one patient who broke the MGH record with a creatinine of 29.3 before submitting to dialysis! A number of my patients had myocardial infarctions in their 20s and 30s, and of the 17 patients in my cohort who have died, the average age of death was 43.

This striking prevalence of coronary artery disease is not surprising given the extraordinary combinations of risk factors that these patients had. Typically, they began smoking heavily in early childhood and consumed a diet extremely high in fat and salt, leading to very early hypertension and diabetes. Indeed, by age 50, 90 percent of my patients were diabetic.

Naturally, they had very strong family histories, compounded by the cultural dictate toward consanguineous marriages: the ideal marriage was thought to be one between second cousins or first cousins, once removed. Among my patients, there even were two first-cousin marriages. The inbreeding coefficient that I observed (0.017) was as high as any previously reported from remote mountain villages.

This disease prevalence in my patient cohort must surely have been unusual, even by Gypsy standards. However, discussions I have had with Gypsy caregivers around the United States convince me that this vasculopathic lifestyle is characteristic of Gypsy culture, and that hypertension, diabetes and coronary disease occur frequently, though perhaps not quite as precociously as I observed.

This lifestyle even had an impact on my ability to study these patients. For example, it was generally impossible to get the patients to come into the hospital in a fasting state to have their lipid levels checked. So, Meg Doucette, my nurse practitioner, and I

would go to their houses in mid-morning as they were rising and draw fasting cholesterol and triglyceride levels. Usually, we would then be invited to share in a hearty Gypsy breakfast, which typically consisted of about two pounds of bacon fried in a large pan with one or two dozen eggs, resembling a giant cholesterol pie. There was little mystery why hyperlipidemia was almost universally observed in this group!

Recognizing the cultural bases for such adverse health habits as tobacco use, obesity, intermarriage, high fat and salt intake, and sedentary lifestyle is essential in caring for the Gypsies. While Gypsies are diligent about taking medications, it is unlikely they will modify their health habits to any significant degree.

Admission to the hospital is one of the most turbulent times in a Gypsy's life. Not only are there the usual concerns of illness and death associated with any serious medical problem, but there are the additional issues of social isolation and *marime*. Throughout a Gypsy's life, he or she is constantly surrounded by friends and relatives; indeed, the worst form of punishment a Gypsy can suffer from a *kris romani* is to be shunned by the *kumpania*. Admission to the hospital is one of the few times that a Gypsy may truly be alone.

Furthermore, the hospital itself is extremely *marime*: not only is it filled with *gaje*, but the food is not prepared in the traditional Gypsy manner, and the usual hospital gown is degrading because it exposes the lower body. To support the patient at the time of hospitalization, *vitsa* members from around the country converge on the hospital. This can lead to chaotic scenes of dozens of Gypsies virtually camping out in the hospital, smoking incessantly, and running up and down the stairs and elevators to the patient's floor.

This family behavior can seem entirely capricious unless it is understood in the context of Gypsy culture. In this regard, we have learned over



Above:
A Gypsy death feast.

time that the single, most important aspect of supporting a Gypsy patient in the hospital is allowing companionship in the room. Accordingly, we now make arrangements to have a single family member stay with the patient at all times. This person needs ready-access to a telephone to communicate with the other relatives waiting in the lobby. With this minor concession, we have been able to get the family to agree not to have additional family members trying to come onto the floor at times other than the visiting hours.

It is critically important that strict lines of communication be established between the patient's medical team and the family. Typically, there will be one member of the family who will take primary responsibility for discussing the medical decisions. This person should hear medical opinions from one member of the patient's primary care team. It is extremely disruptive to have consultants speaking to different family members, because the Gypsies are very astute and capable of detecting even minor discrepancies in what different physicians have told them. It is always preferable to have a single, unified message given to the family.

The Gypsies are an intensely proud cultural group. As such, they expect only the best in medical care, frequently disdaining charity hospitals because "anything free can't be good." They often will know the names of all the chiefs of service in the hospital and demand that care be given by these "big doctors." We have found that it is extremely reassuring to the patient to have a single, brief visit by a well-known physician, who can tell the family that the care they are receiving from the primary physicians is appropriate.

A corollary of this is that *vitsa* elders may try to usurp the decision-making rights of younger or female patients. Careful explanation of the legal and moral requirements of informed consent should help keep the patient "in the loop."

Fears of Gypsy thievery are greatly exaggerated. Although stories abound at many medical centers of Gypsy

thefts of such medical items as EKG monitors and respirators, most of these are purely apocryphal. I have never witnessed the theft of anything of significant value by the Gypsy patients with which I was associated.

Given the striking amount of vascular disease among my patients, it was not surprising that I had to preside over the death of several of my patients. This is a critical ceremony in Gypsy culture, and if the death rites are not handled properly, extreme disruption within the *vitsa* may occur.

The currently "approved" ritual is actually rather simple, in contrast to the recent past, of about 20 years ago, when the patient's bed might have been dragged into the hospital courtyard to assure that death would occur outdoors. Now, as the time of death approaches, the walls of the room must be scrubbed clean and the patient rubbed with holy oil. A candle is lit under the bed to light the way of the soul to heaven, and an open window provided so that the soul may escape. To accommodate the open flame and window in a modern ICU sometimes requires creativity. In one case, we were forced to move a patient in mid-CPR from his ICU bed to the solarium, where an open window was available and where oxygen therapy would not preclude the candle!

At the moment of death, an intense wailing and shrieking erupts from the family. There may be 50 to 100 family members trying to crowd into the patient's room, scratching at their flesh and pulling their hair out in clumps. Many throw themselves against the wall and the floor, shrieking the recently departed's name.

The frenetic grieving, however, does not last very long, typically 15 minutes. Then, the family composes itself and quietly leaves the hospital, leaving disposition of the body to the funeral parlor. Autopsies are strictly taboo in Gypsy culture; if an autopsy is ordered, it may cause great agitation within the family.

Gypsies have an intricate series of funeral rituals, lasting through the first year after death. These begin with a boisterous wake. In Boston, one funeral home has usually been used, which is rented out *in toto* for the three days prior to the funeral. During this time, the body lies in state in a room filled with roses and lilies, and the coffin is filled with items thought to be of value in the afterworld: large sums of money, bottles of whiskey, cases of cigarettes, and even a copy of *TV Guide*.

A flask of water is kept under the coffin. The belief is that as it evaporates, it nourishes the soul. What remains in the flask is poured on the pavement behind the departing hearse on the day of the funeral.

The funerals I was associated with were conducted in local Greek Orthodox churches (making it the second time that the Gypsy had been to church). Though conducted with great solemnity by the orthodox priest, family members seemed to have little regard for the ceremony itself, and wandered in and out of the church throughout the funeral.

Afterwards, a caravan of 50 to 100 cars followed the hearse to the graveyard. Here a picnic table was set up, with cold cuts and a keg of beer. As the coffin is lowered into the ground, accompanied by mountains of flowers, traditionally each attendee pours a cup of beer onto the coffin. At the end, a bottle of Dom Perignon champagne is poured into the grave, followed by a graveside feast for all in attendance.

In the year following a Gypsy's death, four additional feasts are held to celebrate the three-day, nine-day, six-week and twelve-month anniversary of the death. These ceremonies, of course, cannot be held on these dates, because that would be bad luck, so they are traditionally held on the second day, the seventh day, the fourth week, and the eleventh month following death.

The largest of these occur at the fourth-week and eleventh-month marks. At these times, a large church hall is rented and upwards of 500 Gypsies converge from around the country. Long tables are laid out in the shape of a cross, typically the size of a basketball court, and mountains of fruit and flowers adorn the entire length of the tables.

A massive amount of food is prepared by the family, who begins cooking early in the afternoon of the feast. During most of the year, these preparations include several roasted pigs and lambs, along with such Gypsy delicacies as stuffed grape leaves (called *sarme*) and stuffed pigs' stomachs.

Because of their orthodox religion, however, most Gypsies follow a meat-free diet during Lent, during which huge amounts of fish, shrimp and lobsters are prepared for the feast. Ironically, this Lenten diet is not considered healthy and is not followed by Gypsies with heart disease who "need the pig for their strength."

Guests from the *vitsa* and *kumpania* begin arriving at the death feast early in the evening. As I mentioned, many of my first dates with my future wife involved evenings at such ceremonies, and usually we were the only *gaje* present. (I am sure Donna's mother wondered just what my problem was.) As the evening wore on at these death feasts, there was much smoking and drinking, with the men speaking only to other men and the women speaking to the other women. Donna and I were occasionally scolded for speaking to each other, as this was considered disrespectful. When guests got hungry, they would wander back to the kitchen to snack on some of the food being prepared; the actual feast, however, would not take place until late in the evening, usually between 10:00 and 11:00.

As the table begins to fill with food, several rituals are undertaken. One of these involves parading a suit of clothes. A close friend of the deceased is chosen by the family to buy a suit of clothes, usually from Louis (one of Boston's most exclusive clothing stores), complete with all toiletry items, new shoes and underwear. This friend then parades around the feast hall, showing off the clothes to all the

gathered guests.

Following this promenade, a cousin of the deceased lights a plate of incense and after the flame has died down, walks around the table three times, shaking the incense over each plate and chanting "*do zhal do hia*" (for him who is in heaven). Then, two other cousins of the deceased gather at the head of the table, each bearing a torch of 22 candles. These candles are lit using the original candle that was burned under the death bed. They then march around the table in opposite directions, circling it three times.

Up until this point, I noticed, there is relatively little attention paid to the ceremony by the gathered guests; however, with the circling of the torches, the time to eat has arrived. It is clearly important that the guests position themselves to get a seat because there are always more guests than seats available. As the cousins reach the head of the table for the third time, the guests rush to the table to grab a place to sit. Those who cannot sit, however, are still expected to eat, and thus are free to grab anything off the table they desire. At one feast, I had a two-pound lobster snatched off my plate by someone reaching over my shoulder.

Given the length of the ceremony leading up to the feast, I was quite surprised to find that the actual eating lasts only about five minutes. On some signal, unseen by me, all of the guests began stripping the table of its food and putting it into cardboard cartons, which they had all brought to the feast for this purpose. Within minutes, the table was completely bare, and the guests were departing toward home! As they eat the remaining food over the next week, it is believed that they are nourishing the deceased relative in heaven.

Since Donna and I were considered guests of honor, we were always given a bouquet of Gypsy death flowers to display at Donna's apartment, and I would gather up a large cardboard box of roast pig and *sarme* to drop off at the emergency room at Mass. General for the residents on duty.

The coffin is filled with items thought to be of value in the afterworld: large sums of money, bottles of whiskey, cases of cigarettes, and even a copy of TV Guide.

As my residency drew to a close, I made plans to move to Burlington, Vermont to pursue a cardiology fellowship. I assumed that my days as a "Gypsy Doc" were over, until one of my patients remarked to me, "We've been checking it out. There aren't any Gypsies in Burlington. Probably good fortune-telling up there. We think we'll move up with you."

I suppose I shouldn't have been too surprised. After all, what do Gypsies do better than move? In any case, by the time I arrived for my fellowship, 12 of them had moved to Burlington and opened Sasha's Palm and Tarot Card Shop on Church Street, the leading retail area in town. Front-page stories in the local papers soon followed, including one with the headline "Gypsies Follow Trusted Doctor to Vermont." This obviously did a lot for my standing with the local Chamber of Commerce!

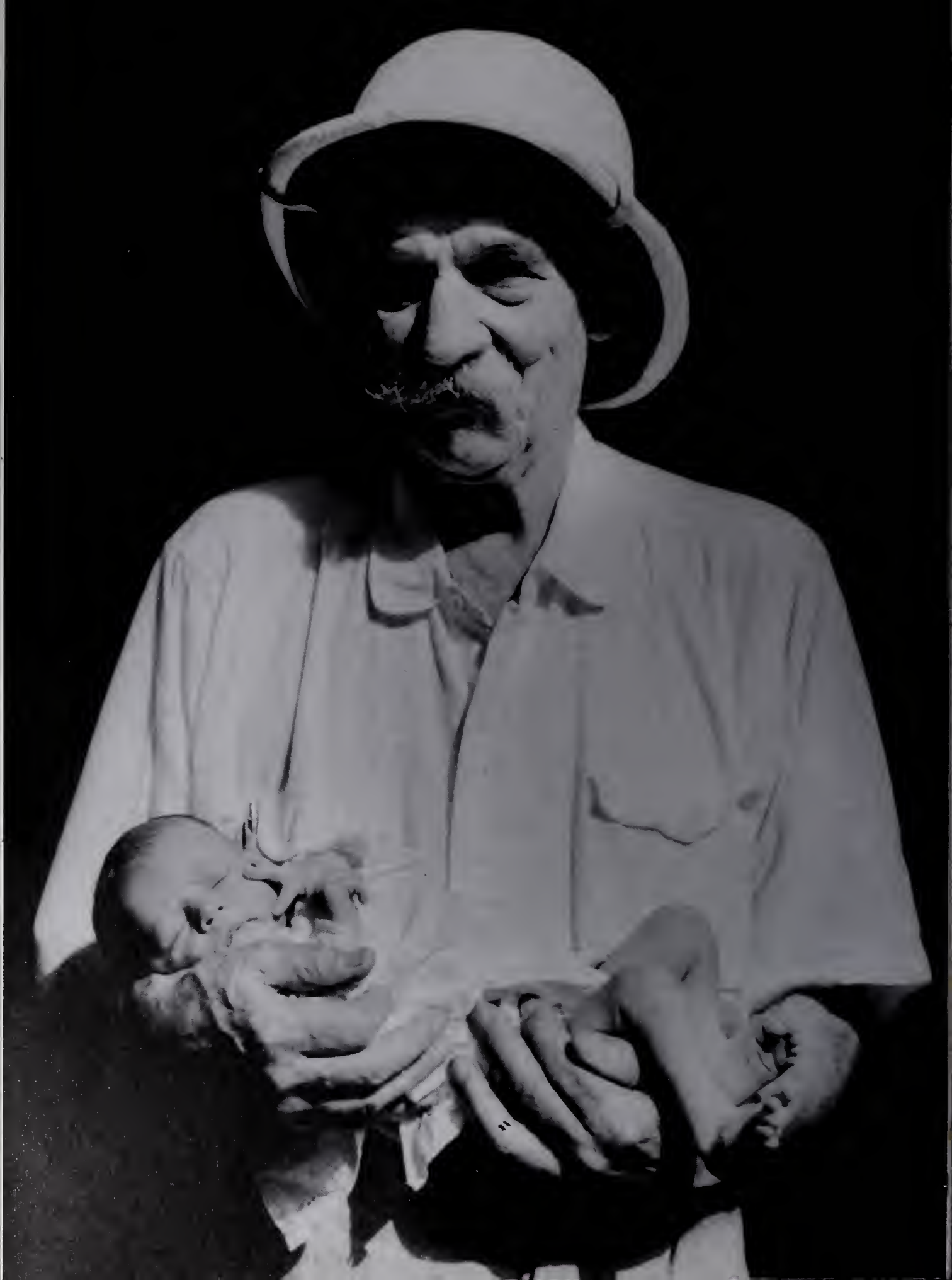
When I left Burlington two years later to return to Mass. General, the Gypsies, likewise, came back to Boston. In the years since, we have remained close friends. Though I am not directly involved in their medical care now, I am considered one of the "big doctors" who may help smooth over some rough spots when a Gypsy is admitted to the hospital.

Sadly, the premature death and almost unbelievable disease combinations have continued. For instance, a 42-year-old Gypsy man was recently receiving topical and systemic therapy on the dermatology service for severe psoriasis when he suffered his second myocardial infarction. Staph sepsis and acute renal failure ensued, followed incredibly, and terminally, by the development of acute myelocytic leukemia.

I place great value on my time with the Gypsies, a fascinating group with as cohesive a culture as any I have encountered. Over the years, they have taught me much about their beliefs and fears. I have learned how important it is to understand the cultural basis for their behavior. Without this knowledge, their actions can seem quite capricious indeed. Armed with this understanding, however, one can discern what their most critical needs during a hospitalization are, make arrangements for these, and negotiate away those aspects of their behavior which may be most disruptive to the workings of the hospital. By so doing, one may have a truly rewarding medical and social relationship with these fascinating people. ✠

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Readers may find more detailed information on his work with these patients in the Annals of Internal Medicine, *1985 (102: 842-84) and the* Lancet, *1987 (2:377-379). An excellent source for understanding American Gypsy culture is Anne Sutherland's book,* Gypsies: The Hidden Americans, *published in London by Tavistock in 1975.*



In the Spirit of Schweitzer

Altruism Beyond Our Jobs

by Robert M. Goldwyn

Three alumni make a case for the less exotic opportunities for altruism here at home.

FEW TASKS ARE AS HAZARDOUS AS urging doctors who already do good to do better, especially in this age of doctor abuse. But, a recent event has prompted a few thoughts.

On October 18 and 19, 1991, I participated in a symposium at the Boston Public Library: "Reverence for Life: The Importance of Albert Schweitzer's Ethic for Boston and the World Today." Its purpose was not simply to eulogize this unusual man and his many magnificent accomplishments, but to translate his example "into effective assistance to those in Boston who are underserved."

The symposium was more than a nostalgic get-together of Schweitzerphiles. Many of the almost 500 attendees had worked in the recent past in Gabon or at the Albert Schweitzer Hospital in Haiti, founded by William Mellon Jr., MD. Many more, perhaps without realizing it, were doing the work of Schweitzer in their efforts on behalf of world peace, nuclear disarmament, the homeless, AIDS sufferers, abused women and children, forgotten elderly and others in desperate need.

Lectures, films, photographs, workshops, discussion groups, informal conversation and two inspiring musical events featuring Yo Yo Ma made the occasion singular because it nicely blended idealism with action. These two days were blessedly free of tiresome rhetoric and exhortation. The symposium validated Schweitzer's dictum: "Example is not the main thing in influencing others—it is the only thing."

Here were people of various ages, though predominantly under 45, of various backgrounds with differing interests and skills, whose concept of self-fulfillment included not only an awareness of the less fortunate but a practical commitment to improve their plight. In the audience, for example, were many students from several medical schools as well as residents who had been working the previous night.

I thought of the contrast with most of my peers when I was a medical student and a resident. Except for momentary lapses into reality, our view of the world was myopic. We seldom looked beyond the bedside. We allowed our concerns to be defined by the dictates of our work.

These people did not have the attitude and the excuse of "Don't bother me. I already gave at the office (hospital)." They were continuing to give of themselves, far more difficult than writing a check, commendable though that may be. Most of us have an idea of where doing something for ourselves or others begins and ends. If each of us could shift the boundaries just a little in favor of others, we could make a substantial difference in the lives of many.

Often, however, although we may have a desire to do something altruistic, we are uncertain about what to choose. We run through the litany: peace group? the homeless? people with AIDS? being a doctor abroad? With regard to the last possibility, my observation is that the greater the distance and the more exotic the place, the easier for doctors to serve others.

The opportunities for aiding those less fortunate are many, but how does one get started? Unlike admission to Harvard Medical School, almost all who apply will be accepted. It is the initial step that is the most difficult.

In what follows, Patricia Schaffer White '86, one of the speakers at the Schweitzer Symposium, reflects on her experience as a physician in the usually neglected area of rural North Carolina, and Lachlan Forrow '83, a principal organizer of the symposium, describes what our students and graduates as well as others have done to extend their concern for those less fortunate, beyond the sphere of their usual professional duties.

Robert M. Goldwyn '56 is clinical professor of surgery at HMS and head of the division of plastic surgery at Beth Israel Hospital.

Our Own Third World

by Patricia Schaffer White

I HAVE MANY VIVID MEMORIES OF living and working in Albert Schweitzer's West African hospital. One in particular keeps haunting me; it's one of those unique memories that becomes highlighted with the passage of time.

My fellow HMS classmate from Los Angeles and I had just begun our journey to the equatorial interior of Gabon. We were sitting in a tightly packed bush van, being jostled amongst brightly clad, smiling Africans and several chickens as we hit dusty pothole after dusty pothole in the unpaved red road. Gazing at the dense forest walls, occasionally punctuated by clusters of primitive shacks made of wood and corrugated tin, which were sheltering several generations of families and domestic animals, my companion sighed and murmured, "Wow. We're really in the Third World!"

This jolted me more than the potholes, because I had just been thinking that the scenes bouncing by us looked barely different from the backroads of North and South Carolina that my family and I used to take on our way to the beach.

This crazy paradox keeps replaying in my mind: many areas of the United States are no different than the "Third World." We have no right to regard ourselves as the most advanced medical society in the world as long as we continue to ignore the "third world" within our own boundaries.

Who are the U.S. third-world citizens, and where do they live? These people are isolated, living in both rural areas and urban ghettoes. Many live in poverty. The most vulnerable are the children, the elderly and the physically and mentally disabled. These people belong to what Albert Schweitzer has called "the Fellowship of those who bear the Mark of Pain," (*On the Edge of the Primeval Forest*, 1961).

After finishing my residency, I left the ivory tower and went back down those backroads of rural South Carolina to the fishing village of McClellanville, a community terribly devastated by Hurricane Hugo. I can testify to the brutal forces of that storm, during which parents had to hold their children up the air ducts in the ceiling to keep them from drowning in the very building designated to be a safe evacuation site.

But I can also tell you that the forces of poverty are no less devastating. In fact, they are more dangerous because they do not receive all the attention of the media.

I think of the pale, thin woman with dark circles under her eyes—28 weeks pregnant—who weighed one pound less than she did prior to pregnancy. Our nurse made a home visit and found her living in a crude structure with no running water and no food in the refrigerator, just a bottle of water. She had three other children with nothing to eat.

I think of the elderly woman crippled by arthritis, who walked into the

clinic using the leg of a table as a cane.

I think of the 19-year-old woman with end-stage renal disease on hemodialysis, whom I treated for hypertensive crisis and pulmonary edema in our rural clinic. During her childhood, no one was there to diagnose her recurrent urinary tract infections, which resulted in her end-stage renal disease.

These are all real human beings who belong to the "Fellowship." Their access to care is very limited. They don't have cars, car seats or monies for transportation, even in serious situations. Well-child visits, immunizations and screenings might be viewed as luxuries, given the hurdles to be leaped. Furthermore, if there is a physician close by, he or she may not accept Medicaid, given the poor reimbursement and bureaucratic hassles.

If this nation produces so many fine, well-trained physicians, where are they? They are in the ivory towers, suburban private practices and surgical subspecialties.

Many of us enter medical school with the idea of serving. Idealism slowly and imperceptibly caves in to many realities. Enormous debts pile up that need to be repaid. After years of grueling residency, which require personal sacrifice, many justifiably want to lead normal, comfortable lives and start a family. Having a family makes you want the best for them, in terms of job opportunities for a spouse, safe neighborhoods, good schools for children, and cultural and recreational activities.

The lure of the ivory tower can be irresistible in many ways. There your intelligence is appreciated by other bright people. "Scut work" and "first call" are done by residents. In stark contrast, if you are in an underserved area, no one may fully appreciate your level of training. After a lifetime of making "A"s and getting into the best schools and residencies, the lack of professional positive reinforcement can leave your self-worth in a vaccuum. Your mentors and peers may not be much help either, with comments such as, "you are wasting your talents."

Another seduction is the draw of the surgical subspecialties. Procedures equal better reimbursement, more respect and better lifestyles.

On one hand, we have the children and the underserved with no political clout, no resources and no access. And on the other side of the chasm, we have the physicians in the ivory towers, suburban private practices and surgical subspecialties. How can we bring these two together?

In many ways the chasm is as deep as the distance from here to Africa is wide. But the problems are chillingly similar. Is it the children's responsibility to muster the resources and clout to bridge this chasm? If we wait, we will watch the infant mortality rate continue to rise, the vaccine-preventable diseases resurge, and the victims of malnutrition and violence multiply.

We should be ashamed.

I suggest that physicians, with their suppressed idealism, enormous intelligence and resources, along with hospitals, government and churches, attempt to bridge this chasm. If we do not lead the way, the government may do so and rob us of the independence we now enjoy.

What can we do? Not everyone can be an Albert Schewitzer, but everyone can help in some way. For example, we can encourage careers in primary care: in pediatrics, internal medicine and family medicine. These physicians can provide the majority of needed services. Instead, Harvard, for one, does not even have a family practice department. Pediatric residents throughout the country are spending more and more time in the NICU instead of in general pediatrics. I wish they could also spend time doing prenatal care. Residents are being trained to meet the needs of hospitals—not the needs of our society.

Other ways to better meet these needs include exposing students and residents to primary care physicians as role models and teachers; giving more equitable Medicare reimbursement, a problem that the RBRVS (resource based relative value scale) is now addressing; and dedicating part or all of your life to serving those in need.

There are many ways you can find your own Lambaréné. Here are some examples of ways I have seen people serve:

- Take one to two years after residency to work in an underserved area.
- Join the Public Health Service or Indian Health Service Corps; both offer loan repayment assistance.
- Work one-half day per week at your health department.
- Join mission projects through your church.
- Form a medical clinic with other doctors, perhaps from area churches, that is open in the evening to serve those in need.
- Accept Medicaid.
- Contact your local hospital and offer to do indigent care for a salary. You serve and the hospital saves money by keeping unnecessary ER visits to a minimum.

The ways you can serve are only limited by your imagination. Expect to meet obstacles. Albert Schweitzer's sponsoring church withdrew its monetary support for his African medical mission due to technical theological differences. Instead of being discouraged, he raised the money himself by giving organ recitals. When he was imprisoned in World War I for being a German in French Equatorial Africa, he rallied from depression and physical weakness to return. Our obstacles are mere speed bumps.

When I first arrived at Schweitzer's hospital 19 years after his death, I was terribly discouraged with the cynical and sometimes racist attitudes of the doctors. I wondered, where is Schweitzer's spirit, his love and his reverence for life? After becoming busy treating so many Africans, I

began to experience that joy of service, of making a difference, of helping to erase "the Mark of Pain." Thus, I discovered Schweitzer's spirit within myself.

I have been told that there is a potential for burnout, given the overwhelming needs and limited personal resources. Most in this line of work rely on spiritual replenishment or peer support. In other words, you will need to be in touch with forces greater than yourself. As Yo Yo Ma put it so eloquently during the October symposium: "The pulse is there and you become a part of it."

Immeasurable joy can be found in serving those in need. Intangible awards await. I will close with an example. Last year I saw a three-year-old girl whose mother brought her 60 miles to see me for a fine papular rash. Since her rapid strep test was negative, I suggested that she have a viral exanthem.

Two days later they returned and I barely recognized the child. She had a fever of 104°; her scalp was crusted with oozing sores; her skin was thick and scaly like that of an alligator; one ear was cracked and bleeding; and worst of all, she had right-sided periorbital erythema, edema and tenderness. She clearly had periorbital cellulitis, which needed immediate treatment, but I could not sort out all the unusual skin findings. I called the medical university for consultation and was advised to consult my local pediatric ophthalmologist and dermatologist.

I was stunned at the thought as I gazed out the window at the hurricane-devastated countryside. There were no pediatricians within 60 miles who would see Medicaid patients, much less a pediatric ophthalmologist and dermatologist.

With the help of a dedicated pediatrician 60 miles away and 120 miles from the patient's home, we found that the child had an unusual fungal scalp infection to which she had had an ID reaction, which then had become superinfected with strep. After 10 days of treatment, she was again beautiful and well.

Seeing her smile and her mother's eyes shining with gratitude gave me so much happiness. What a privilege to be able to make a difference. The need for accolades from peers falls away. As in Lambaréné, I discovered the spirit of Albert Schweitzer within myself.

I cannot predict the outcome of your service to needy people. Some achieve great distinction and fame for their work. Many find tremendous satisfaction knowing they are doing a service where no one else is standing by to fill their shoes. For others, it is important to stand on the right side of human medical history.

For me, the reward is quite simple and yet profound. It is the warm memories of helping to erase "the Mark of Pain" off real human faces and witnessing the emergence of a healthy child's smile and a mother's eyes filled with gratitude. Take your gifts across the chasm. The children and those forgotten by society are waiting for you on the other side with gifts of their own.

Patricia Schaffer White '86 is a family physician working in both rural Davidson, North Carolina and urban Charlotte, North Carolina. She is a member of the board of the Albert Schweitzer Fellowship. Her career interest is indigent health care.

The Power of Example

by Lachlan Forrow

In 1982 I was selected to be one of four Harvard Medical School students who traveled over 5,000 miles to the Albert Schweitzer Hospital in Lambaréné, Gabon to serve for three months as an Albert Schweitzer Fellow. Since 1979, nearly 50 HMS students have made this trip, providing vitally needed medical and pediatric care at the hospital that Schweitzer founded in 1913.

Each year now, I interview students applying for this program, and I meet with them after their return from Africa. It is inspiring to sense their energy and commitment as they describe how deeply rewarding it can be to make a concrete difference in the health of individuals whose medical care would otherwise simply be inadequate, and how much satisfaction there is in engaging in caring relationships that cross the chasms of ethnic, cultural and socioeconomic differences.

Increasingly, however, we Americans are recognizing that within our own communities there are unmet health problems that at times rival those of the so-called Third World. Infant mortality rates are worse than in some developing countries. Adult black men in Harlem have a shorter life expectancy than men in Bangladesh. In the communities surrounding some of our own city's world-renowned hospitals, barely half of expectant mothers receive adequate prenatal care. Epidemics of AIDS, drugs

and urban violence are destroying our youth.

In fact, the challenging opportunities that exist in Africa—to make an immediate difference in ways that are personally rewarding—also exist just blocks from most of our workplaces.

In 1992 the Albert Schweitzer Fellowship of America therefore launched the Schweitzer Urban Fellows Program, through which local health professional students are selected to serve as Albert Schweitzer Urban Fellows in existing community outreach organizations in the greater Boston area. Made possible by a grant from the Harvard Community Health Plan Foundation, this program is designed to connect young professionals with opportunities to engage in activities through which their initially abstract idealism can become solid reality.

Repeatedly, however, students have expressed concern about the relatively small number of visible role models for this kind of work. Almost daily in their pre-clinical education they are introduced to inspiring faculty who have devoted their lives to addressing the urgent research questions upon which the future capabilities of medicine so directly depend. Every day in their clinical rotations they are exposed to faculty and practitioners whose commitment to excellence in the care of patients who have reached our extraordinary hospitals is also inspiring. Almost never, however, do students meet role models who have incorporated activities of outreach to underserved members of our community into their professional lives.

As Schweitzer understood so well, there can be no more powerful influence on the professional development of students than the power of example. The students participating in this program will themselves be examples to other students. Just as central to the long-term success of this initiative will be the involvement of experienced practitioners who demonstrate a sustained commitment to the underserved well into one's mature professional years.

The range of unmet health needs in our community is so extensive and varied that any practitioner with a desire to contribute can find an opportunity through which his or her skills and capacity as a mentor would be invalu-

Albert Schweitzer Urban Fellows Program

The following examples are adapted from the brochure of the 1992 Schweitzer Urban Fellows Program (SUFP), which was distributed throughout Boston's medical, public health, dental, nursing, and social work schools. The first 12 urban fellows, including 3 HMS students, will begin their projects this summer and fall. A much more comprehensive list of opportunities is being compiled by a city-wide group involving the SUFP, the HMS Office of Student Affairs, HSPH, and other institutions with schools of medicine, public health and nursing such as Boston University, Tufts, Northeastern, and Mass. General Hospital.

AIDS

Some Schweitzer Fellows and their mentors will engage in activities contributing to AIDS prevention, to the care of persons with AIDS, and/or to advocacy on behalf of those needing treatment or social services. At sites such as Dimock Community Health Center—whose president, Jackie Jenkins-Scott, serves as a co-chair of the Schweitzer Urban Fellows Program—fellows assist with the design and implementation of educational programs for inner Boston caregivers, patients and families and can make a direct difference in how effectively the HIV epidemic is addressed in our inner city. Other organizations collaborating with the Schweitzer Urban Fellows Program include AIDS Action Committee, the HIV education programs of the Department of Health and Hospitals, and Fenway Community Health Center, which provide a wide range of opportunities for participation in advocacy, counseling, education and treatment programs.

HOMELESSNESS

Working with the Boston Health Care for the Homeless Program, under the leadership of medical director Jim O'Connell '82, participants in the SUFP are needed to serve with the multidisciplinary teams of physicians, nurse practitioners and case workers who provide primary and episodic health care to homeless individuals and families at Massachusetts General Hospital and Boston City Hospital, as well as more than 40 other outreach sites. Through Alliance for the Homeless, Inc., led by Ross Neisuler '66, a Schweitzer Fellow might assist in the operation and policy development of on-site medical clinics in six homeless shelters as well as aid in the genesis of a central consulting service.

able. In some cases, what is simply needed is that the work of those already involved in service activities be made more visible to magnify the power of their example. In other cases, individuals may need to learn more about the wide range of possible projects, so that they may pick one that fits best into his or her own professional work and personal life.

We are currently engaged in a Boston-wide effort to identify specific community-based opportunities for service, particularly those in which a health professional student might be paired with an experienced practitioner/mentor. Examples of some of these available in the Boston area are described here—almost any community will have similar opportunities.

Schweitzer wrote that "great ideals are lost at every moment because we miss opportunities, but the ideals that are turned into will and action constitute a richness that must not be undervalued." The moral commitment to safeguarding human health that drew all of us into medicine remains for many of us the source of the deepest satisfaction we find in our professional work. With expanded involvement in outreach activities, through which we not only make an immediate difference in our community, but also influence the professional development of our colleagues in training, we can all derive great rewards.

Lachlan Forrow '83 is vice president of the Albert Schweitzer Fellowship of America and HMS instructor in medicine at the Beth Israel Hospital.

CHILDREN AND YOUTH

Working with Bridge Over Troubled Waters, Inc., individuals can join volunteers like HMS Instructor in Medicine Larry Friedman in mentoring students who serve on the Bridge Free Medical Van, providing mobile medical care to youth on the streets. In 1992 the Boston Latin School would like a Schweitzer Fellow to develop a model outreach program that involves health professional students as teachers and mentors. They would assist public high school students who are trying to develop a counseling and support network to address self-destructive behavior among their peers.

Working through community-based sites such as Dimock and Roxbury Comprehensive Health Center, 1992 Schweitzer Fellow Diana Currie '93 will help insure effective outreach and support for teen mothers and their infants.

CARE AT THE END OF LIFE

At Trinity Hospice of Greater Boston, Inc., 1992 Schweitzer Fellow Jack West '95 will collaborate with staff such as medical director J. Andrew Billings '71 in the design and implementation of a hospice program with special outreach to communities of color, the poor, persons living alone and persons with AIDS. Other opportunities are available in coordination with Elizabeth Kass, MD, HMS instructor in medicine and medical director of the Hospice at Mission Hill, devoted primarily to the care of patients with AIDS.

VIOLENCE AGAINST WOMEN

Working with nurse practitioners from neighborhood health centers, 1992 Schweitzer Fellow Lynette Wroblewski '94 will participate in the work of Transition House, addressing the health, human and social service needs of battered women and their children. Through the community programs against sexual assault of the Roxbury Multi-Service, a Schweitzer Fellow might participate in rape awareness education for the general public or in support groups for rape and incest survivors.

OTHER OPPORTUNITIES

A wide range of opportunities are available in Cambridge through the Cambridge Health of the City Program, particularly for those interested in safeguarding the health of children and of men of color. Co-chaired by David Bor, HMS assistant professor of medicine, this program already involves several other HMS faculty, including Ronald Arky, MD, David Link, MD, David Nathan '55, Richard Pels, MD, Michelle Holmes '81 and Gordon Moore '63.

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